Alabama

UNIFORM APPLICATION
FY 2008

SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT

OMB - Approved 09/20/2007 - Expires 09/30/2010

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Center for Substance Abuse Treatment
Division of State and Community Assistance

Introduction:

The SAPT Block Grant application format provides the means for States to comply with the reporting provisions of the Public Health Service Act (42 USC 300x-21-64), as implemented by the Interim Final Rule and the Tobacco Regulation for the SAPT Block Grant (45 CFR Part 96, parts XI and IV, respectively).

Public reporting burden for this collection of information is estimated to average 563 hours per response for sections I-III, 50 hours per response for Section IV-A and 42 hours per response for Section IV-B, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to SAMHSA Reports Clearance Officer; Paperwork Reduction Project (0930-0080); Room 16-105, Parklawn Building; 5600 Fishers Lane, Rockville, MD 20857.

An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. The OMB control number for this project is 0930-0080.

Form 1

State: Alabama
DUNS Number: 929956324-

Uniform Application for FY 2008 Substance Abuse Prevention and Treatment Block Grant

I. STATE AGENCY TO BE THE GRANTEE FOR THE BLOCK GRANT

Agency Name: Alabama Department of Mental Health and Mental Retardation

Organizational Unit: Substance Abuse Services Division

Mailing Address: 100 North Union Street

City: Montgomery Zip: 36130-1410

II. CONTACT PERSON FOR THE GRANTEE FOR THE BLOCK GRANT

Name: John Houston

Agency Name: Alabama Department of Mental Health and Mental Retardation

Mailing Address: 100 North Union Street

City: Montgomery Zip Code: 36130-1410

Telephone: (334) 242-3107 FAX: (334) 242-0684

E-MAIL: john.houston@mh.alabama.gov

III. STATE EXPENDITURE PERIOD

From: 10/1/2004 To: 9/30/2005

IV. DATE SUBMITTED

Date: 10/1/2007 4:37:05 PM ☒ Original ☐ Revision

V. CONTACT PERSON RESPONSIBLE FOR APPLICATION SUBMISSION

Name: Brandon Folks Telephone: (334) 353-7175

E-MAIL: brandon.folks@mh.alabama.gov FAX: (334) 242-0759

Form 2 (Table of Contents)

State:
Alabama

UNIFORM APPLICATION FOR FY 2008 SUBSTANCE ABUSE PREVENTION AND TREATMENT BLOCK GRANT
Funding Agreements/Certifications
as Required by the Public Health Service (PHS) Act

The PHS Act, as amended, requires the chief executive officer (or an authorized designee) of the applicant organization to certify that the State will comply with the following specific citations as summarized and set forth below, and with any regulations or guidelines issued in conjunction with this Subpart except as exempt by statute.

We will accept a signature on this form as certification of agreement to comply with the cited provisions of the PHS Act. If signed by a designee, a copy of the designation must be attached.

I. Formula Grants to States, Section 1921

Grant funds will be expended "only for the purpose of planning, carrying out, and evaluating activities to prevent and treat substance abuse and for related activities" as authorized.

II. Certain Allocations, Section 1922

- **Allocations Regarding Primary Prevention Programs, Section 1922(a)**
- **Allocations Regarding Women, Section 1922(b)**

III. Intravenous Drug Abuse, Section 1923

- **Capacity of Treatment Programs, Section 1923(a)**
- **Outreach Regarding Intravenous Substance Abuse, Section 1923(b)**

IV. Requirements Regarding Tuberculosis and Human Immunodeficiency Virus, Section 1924

V. Group Homes for Recovering Substance Abusers, Section 1925
Optional beginning FY 2001 and subsequent fiscal years. Territories as described in Section 1925(c) are exempt.

The State "has established, and is providing for the ongoing operation of a revolving fund" in accordance with Section 1925 of the PHS Act, as amended. This requirement is now optional.

VI. State Law Regarding Sale of Tobacco Products to Individuals Under Age of 18, Section 1926:

- **The State has a law in effect making it illegal to sell or distribute tobacco products to minors as provided in Section 1926 (a)(1).**
- **The State will enforce such law in a manner that can reasonably be expected to reduce the extent to which tobacco products are available to individuals under the age of 18 as provided in Section 1926 (b)(1).**
- **The State will conduct annual, random unannounced inspections as prescribed in Section 1926 (b)(2).**

VII. Treatment Services for Pregnant Women, Section 1927

The State "…will ensure that each pregnant woman in the State who seeks or is referred for and would benefit from such services is given preference in admission to treatment facilities receiving funds pursuant to the grant."

VIII. Additional Agreements, Section 1928

- **Improvement of Process for Appropriate Referrals for Treatment, Section 1928(a)**
- **Continuing Education, Section 1928(b)**
- **Coordination of Various Activities and Services, Section 1928(c)**
- **Waiver of Requirement, Section 1928(d)**

IX.	**Submission to Secretary of Statewide Assessment of Needs, Section 1929**
X.	**Maintenance of Effort Regarding State Expenditures, Section 1930**
	With respect to the principal agency of a State, the State "will maintain aggregate State expenditures for authorized activities at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant."
XI.	**Restrictions on Expenditure of Grant, Section 1931**
XII.	**Application for Grant; Approval of State Plan, Section 1932**
XIII.	**Opportunity for Public Comment on State Plans, Section 1941**
	The plan required under Section 1932 will be made "public in such a manner as to facilitate comment from any person (including any Federal person or any other public agency) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary."
XIV.	**Requirement of Reports and Audits by States, Section 1942**
XV.	**Additional Requirements, Section 1943**
XVI.	**Prohibitions Regarding Receipt of Funds, Section 1946**
XVII.	**Nondiscrimination, Section 1947**
XVIII.	**Services Provided By Nongovernmental Organizations, Section 1955**
	I hereby certify that the State or Territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act, as amended, as summarized above, except for those Sections in the Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.
State: Alabama	
Name of Chief Executive Officer or Designee: Bob Riley	
Signature of CEO or Designee:	
Title: Governor	**Date Signed:**
If signed by a designee, a copy of the designation must be attached	

1. CERTIFICATION REGARDING DEBARMENT AND SUSPENSION

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 45 CFR Part 76, and its principals:

(a) are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;

(b) have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;

(c) are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and

(d) have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, In eligibility, and Voluntary Exclusion – Lower Tier Covered Transactions" in all lower tier covered transactions (i.e., transactions with sub-grantees and/or contractors) and in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

2. CERTIFICATION REGARDING DRUG-FREE WORKPLACE REQUIREMENTS

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug-free work-place in accordance with 45 CFR Part 76 by:

(a) Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's workplace and specifying the actions that will be taken against employees for violation of such prohibition;

(b) Establishing an ongoing drug-free awareness program to inform employees about –
(1) The dangers of drug abuse in the workplace;
(2) The grantee's policy of maintaining a drug-free workplace;
(3) Any available drug counseling, rehabilitation, and employee assistance programs; and
(4) The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;

(c) Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;

(d) Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will –
(1) Abide by the terms of the statement; and
(2) Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;

(e) Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;

(f) Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted –

(1) Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or

(2) Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;

(g) Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), (c), (d), (e), and (f).

For purposes of paragraph (e) regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Office of Grants and Acquisition Management
Office of Grants Management
Office of the Assistant Secretary for Management and Budget
Department of Health and Human Services
200 Independence Avenue, S.W., Room 517-D
Washington, D.C. 20201

3. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that:

(1) No Federal appropriated funds have been paid or will be paid, by or on behalf of the under signed, to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.

(2) If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities, "in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)

(3) The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, sub-grants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Service strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE Commissioner
APPLICANT ORGANIZATION AL Dept. of MH/MR	DATE SUBMITTED

DISCLOSURE OF LOBBYING ACTIVITIES

Complete this form to disclose lobbying activities pursuant to 31 U.S.C. 1352
(See reverse for public burden disclosure.)

1. Type of Federal Action:	2. Status of Federal Action	3. Report Type:
☐ a. contract b. grant c. cooperative agreement d. loan e. loan guarantee f. loan insurance	☐ a. bid/offer/application b. initial award c. post-award	☐ a. initial filing b. material change **For Material Change Only:** Year _____ Quarter _____ date of last report

4. Name and Address of Reporting Entity:	5. If Reporting Entity in No. 4 is Subawardee, Enter Name and Address of Prime:
☐ Prime ☐ Subawardee Tier _____ , if known: _____	
Congressional District, *if known:* _____	**Congressional District**, *if known:* _____
6. Federal Department/Agency:	**7. Federal Program Name/Description:** **CFDA Number**, *if applicable:* _____
8. Federal Action Number, if known:	**9. Award Amount,** if known: $
10. a. Name and Address of Lobbying Entity *(if individual, last name, first name, MI):*	**b. Individuals Performing Services** *(including address if different from No. 10a.) (last name, first name, MI):*
11. Information requested through this form is authorized by title 31 U.S.C. Section 1352. This disclosure of lobbying activities is a material representation of fact upon which reliance was placed by the tier above when this transaction was made or entered into. This disclosure is required pursuant to 31 U.S.C. 1352. This information will be reported to the Congress semi-annually and will be available for public inspection. Any person who fails to file the required disclosure shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.	**Signature:** _____ **Print Name:** _____ **Title:** _____ **Telephone No.:** _____ **Date:** _____

Federal Use Only:	Authorized for Local Reproduction Standard Form - LLL (Rev. 7-97)

DISCLOSURE OF LOBBYING ACTIVITIES
CONTINUATION SHEET

Reporting Entity: **Page** **of**

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Standard Form – LLL -A

INSTRUCTIONS FOR COMPLETION OF SF-LLL, DISCLOSURE OF LOBBYING ACTIVITIES

This disclosure form shall be completed by the reporting entity, whether subawardee or prime Federal recipient, at the initiation or receipt of a covered Federal action, or a material change to a previous filing, pursuant to title 31 U.S.C. Section 1352. The filing of a form is required for each payment or agreement to make payment to any lobbying entity for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with a covered Federal action. Use the SF-LLL-A Continuation Sheet for additional information if the space on the form is inadequate. Complete all items that apply for both the initial filing and material change report. Refer to the implementing guidance published by the Office of Management and Budget for additional information.

1. Identify the type of covered Federal action for which lobbying activity is and/or has been secured to influence the outcome of a covered Federal action.

2. Identify the status of the covered Federal action.

3. Identify the appropriate classification of this report. If this is a follow-up report caused by a material change to the information previously reported, enter the year and quarter in which the change occurred. Enter the date of the last previously submitted report by this reporting entity for this covered Federal action.

4. Enter the full name, address, city, state and zip code of the reporting entity. Include Congressional District, if known. Check the appropriate classification of the reporting entity that designates if it is, or expects to be, a prime or subaward recipient. Identify the tier of the subawardee, e.g., the first subawardee of the prime is the 1st tier. Subawards include but are not limited to subcontracts, subgrants and contract awards under grants.

5. If the organization filing the report in item 4 checks subawardee , then enter the full name, address, city, state and zip code of the prime Federal recipient. Include Congressional District, if known.

6. Enter the name of the Federal agency making the award or loan commitment. Include at least one organizational level below agency name, if known. For example, Department of Transportation, United States Coast Guard.

7. Enter the Federal program name or description for the covered Federal action (item 1). If known, enter the full Catalog of Federal Domestic Assistance (CFDA) number for grants, cooperative agreements, loans, and loan commitments.

8. Enter the most appropriate Federal identifying number available for the Federal action identified in item 1 [e.g., Request for Proposal (RFP) number; Invitation for Bid (IFB) number; grant announcement number; the contract, grant, or loan award number; the application/proposal control number assigned by the Federal agency]. Include prefixes, e.g., RFP-DE-90-001.

9. For a covered Federal action where there has been an award or loan commitment by the Federal agency, enter the Federal amount of the award/loan commitment for the prime entity identified in item 4 or 5.

10. (a) Enter the full name, address, city, state and zip code of the lobbying entity engaged by the reporting entity identified in item 4 to influence the covered Federal action.

    (b) Enter the full names of the individual(s) performing services, and include full address if different from 10(a). Enter Last Name, First Name, and Middle Initial (MI).

11. Enter the amount of compensation paid or reasonably expected to be paid by the reporting entity (item 4) to the lobbying entity (item 10). Indicate whether the payment has been made (actual) or will be made (planned). Check all boxes that apply. If this is a material change report, enter the cumulative amount of payment made or planned to be made.

ASSURANCES NON-CONSTRUCTION PROGRAMS

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0040), Washington, DC 20503.

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

Note: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.

2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.

3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.

4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.

5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM s Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).

6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L.88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685- 1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non- discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.

7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.

8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.

9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327- 333), regarding labor standards for federally assisted construction subagreements.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.

11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.

13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.).

14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.

15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.

16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.

17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.

18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

SIGNATURE OF AUTHORIZED CERTIFYING OFFICIAL	TITLE Commissioner
APPLICANT ORGANIZATION AL Dept. of MH/MR	DATE SUBMITTED

State:
Alabama

FY 2005 SAPT BLOCK GRANT

Your annual SAPT Block Grant Award for FY 2005 is reflected on Line 8 of the Notice of Block Grant Award

$24,007,464

Alabama

Goal #1: Continuum of Substance Abuse Treatment Services

GOAL # 1. The State shall expend block grant funds to maintain a continuum of substance abuse treatment services that meet these needs for the services identified by the State. Describe the continuum of block grant-funded treatment services available in the State (See 42 U.S.C. 300x-21(b) and 45 C.F.R. 96.122(f)(g)).

FY 2005 (Compliance):

FY 2007 (Progress):

FY 2008 (Intended Use):

FY 2005 (COMPLIANCE)
Goal #1: The Alabama Substance Abuse Services Division will utilize not less than 80% of the grant for treatment services regarding alcohol and other ugs.

Objective #1: Utilize a contracting and service reporting system to assure that not less than 80% of the Block Grant is utilized for treatment services regarding alcohol and other drugs.

COMPLIANCE: The continuum of substance abuse care in Alabama included; prevention, information and referral, assessment, outpatient, intensive outpatient, detoxification, short-term residential, long-term residential, case þÿ m a n a g e m e n t , s p e c i a l i z e d w o m e n s s e r v i c e s methadone treatment. The SASD contracted with fifty community organizations for the provision of prevention and treatment services (refer to Form 6). The SASD utilized a fee-for-service contract mechanism that included a Billing Manual which defined services, established reimbursement rates, identified service billing codes, defined the client population, etc. Contractors submitted monthly billing documentation including the NIDA Minimum Data Set, client identification, service provided, length of service, etc. The system in operation in 2005 required collection of the described data elements for all services reimbursed by the SASD, including those paid with SAPT Block Grant Funds. The SASD did not collect information regarding the expenditure of local funding but all contracted programs receive some local funding for the support of prevention and treatment services. In 2005 outcome data was not required and therefore was not collected. Expenditures from the 2005 SAPT Block Grant were tracked to the individual client level through the Stand-Alone Uniform Data Reporting System (SUDS). Reports regarding expenditures and service information for the SAPT Block Grant Application are generated from the SUDS data system.

FY 2007 (PROGRESS)
FY 2007 (Progress):

Activity: The Alabama Substance Abuse Services Division will use a coding system for funds and services which identifies alcohol and drug treatment.

Current Status: The alcohol and drug coding system is being used.

Activity: Block Grant treatment money will be put into community contracts for the purchase of treatment services to clients with an alcohol and/or drug related DSM IV TR diagnosis

Activity: Each treatment service reported for payment will be identified by separate treatment service codes.

Current Status: Each treatment service that is reported for reimbursement is identified by a treatment service code.

Activity: The Alabama Substance Abuse Services Division will operate in accordance with a Billing Manual defining the treatment services to be purchased under the contract.

Current Status: The Billing Manual is being applied and modifications are being made where necessary.

FY 2008 (INTENDED)
FY 2008 (Intended Use):

þÿ T h e S A S D i s i n t h e m i d s t o f a S y s t e m I m
the implementation of standardized screening and assessment instruments, adopting ASAM level of care determination, expanded ASAM levels of care and client enrollment with a unique identifier. Unfortunately, these expansions will not be implemented until October 1, 2008. Therefore, the SASD will continue the same continuum of care as described above for FY 2008. SAPT Block Grant funds will be contracted with the same providers using the same billing and reporting requirements although outcome measures will be collected and reported.

The SASD provides no direct services, all prevention and treatment services are provided by contracting community providers. Most of the fifty community contractors provide direct care. The SASD contracts with two intermediaries one of which is also a direct service provider. Even though two intermediaries are used, contract providers report expenditure and service data directly to SASD.

Alabama receives no funding through ATR, SBIRT or COSIG. However, we are in the last year of a State Incentive Grant (SIG) which is used to support the efforts of twelve coalitions and Auburn University as the evaluator for the grant.

SAPT Block Grant priority population requirements are stipulated in all service contracts. Contractual requirements to serve priority populations will continue.

The SASD has established three primary goals for services expansion. Each of these goals will be addressed as funding is available.

1. By 2012, accessible adult and adolescent, evidence-based, treatment services will be available in every county. Increasing the number of counties offering adult substance abuse treatment services by five each year (starting with a baseline of thirty-two counties with services in FY 05-06). Increasing the number of counties offering adolescent substance abuse treatment services by nine each year (starting with a baseline of twenty counties with services in FY 05-06).

2. By 2012, accessible prevention services will be available in every county. Increasing the number of counties offering prevention services by nine each year (beginning with a baseline of twenty-three counties with services in FY 05-06).

3. By 2012, active advocacy efforts driven by consumers and family members will exist in every county. Increasing the number of counties with advocacy efforts by eleven each year (beginning with a baseline of ten counties efforts in FY 05-06).

The Legislature made $2,000,000 available for substance abuse treatment support for the criminal justice population, particularly for new drug courts. The SASD will contract with certified treatment providers that are selected by the new drug courts and provide expanded services for other individuals needing substance abuse treatment referred through the criminal justice system. The location of the new and expanded treatment services will be determined by the schedule of implementation of the new drug courts. The goal is to have model drug courts in all sixty-seven counties in Alabama.

Alabama

Goal #2: 20% for Primary Prevention

GOAL # 2. An agreement to spend not less than 20 percent on primary prevention programs for individuals who do not require treatment for substance abuse, specifying the activities proposed for each of the six strategies or by the Institute of Medicine Model of Universal, Selective, or Indicated as defined below: (See 42 U.S.C. 300x-22(a)(1) and 45 C.F.R. 96.124(b)(1)).

Institute of Medicine Classification: Universal Selective and Indicated:

- Universal: Activities targeted to the general public or a whole population group that has not been identified on the basis of individual risk.
  - Universal Direct. Row 1—Interventions directly serve an identifiable group of participants but who have not been identified on the basis of individual risk (e.g., school curriculum, afterschool program, parenting class). This also could include interventions involving interpersonal and ongoing/repeated contact (e.g., coalitions)
  - Universal Indirect. Row 2—Interventions support population-based programs and environmental strategies (e.g., establishing ATOD policies, modifying ATOD advertising practices).This also could include interventions involving programs and policies implemented by coalitions.

- Selective: Activities targeted to individuals or a subgroup of the population whose risk of developing a disorder is significantly higher than average.
- Indicated: Activities targeted to individuals in high-risk environments, identified as having minimal but detectable signs or symptoms foreshadowing disorder or having biological markers indicating predisposition for disorder but not yet meeting diagnostic levels. (Adapted from The Institute of Medicine Model of Prevention)

FY 2005 (Compliance):

FY 2007 (Progress):

FY 2008 (Intended Use):

FY 2005 (COMPLIANCE)
FFY 2005 Compliance

The Office of Prevention has commenced with the overall goals of the Systems Improvement Initiative set forth by the direction of the Single State Authority director. The Systems Improvement involves a new management information system to capture data and ultimately document outcomes in the Prevention area. A new system of Prevention Planning in community-based organizations has involved a new planning system that captures the Strategic Prevention Framework. It is the goal of the Office of Prevention to effect change in all sixty-seven (67) counties in the state to build infrastructure and capacity for Prevention services and practices. The overall goals of the Office of Prevention have been expanded. The continuum of care will be strengthened to support the existing goals of the 32 county catchment areas. Programs are now defined in two specific areas of concentration. Fifty (50%) of the Block Grant will be utilized for Education and Alternative programs, and the remaining fifty (50%) is utilized for Environmental Strategies in each county catchment area. The North and the South Clearinghouse gave dissemination support for all resource development support rendered to community providers. Resource Development þÿ m a t e r i a l i s p e r i o d i c a l s , r e s e a r c h , D V D s materials, State and national prevention trainings and meetings. The following table for block grant recipients in the state that describes all of the current strategies utilized under the funding source.

Table: County / Environmental Strategy / Education & Alt. Strategies / Target Population
Agency
[County Served] ENVIRONMENTAL STRATEGY ED & ALT STRATEGIES
Abbreviations: þÿ T G f D T o o G o o d f o r TARGET POPULATION
1. West Alabama MHC
[Choctaw, Greene, Hale, Marengo, Sumter]

2. ARS, Inc. JBS
[Jefferson, Blount, St. Claire]
Decreasing usage/underage consumption of alcohol [Marengo / Hale counties]

Mobilize Pratt City Community- decrease underage consumption of alcohol in African American children þÿ - T o o G o o d f o r D r u g s ; þÿ P a r e n t i n g W i s e l y ; T o o G o o d f o r D r u g s þÿ - T G D & V i o l e n c e B e t h e l & C o m m u n i t y C

þÿ - T G f D r u g s - s c h o o l
þÿ T G f D & V i o l 5th Graders s c h o o l
Family

11-16 year olds

FY 2005 (COMPLIANCE)
6th & 9th Graders
6th Graders
9th Graders

Partner w/ 3 local merchant stores
þÿ - T G f D & V i o l e n c e - C o m m u n i t y

6th & 9th Graders

Community youth
3. Chilton-Shelby MHC
[Chilton, Shelby Counties] Decrease use of alcohol in underage population-Chilton County H.S. þÿ - T G f D r u g s & T G þÿ V i o l e n c e

10th Graders

4. East Central MHC
[Macon, Pike, Bullock]

Reduce exposure of Pike County residents to marijuana
þÿ - L i f e S k i l l s M . S . ; - E l e m S c h o o l þÿ - L i f e S k i l l s . B a p t i s t
-Summer; Spring Break
-Community: Baptist Church

5th Graders

5th Graders

5th Graders, siblings & parents

5. ASAC [Cherokee]
[Dekalb, Cherokee, Etowah]
Decrease tobacco usage-[local middle schools] change community standards, codes, attitudes; review school drug policies 10-14 yr olds

6. Aletheia House [JBS]
[Jefferson, Blount, St. Claire]
Increase capacity of Fairview neighborhood to reduce environmental risk factors
þÿ - K i d s W h o C a r e - c o m m u n i t y c h u r c h

9-13 yr olds

7. Baldwin County MHC
[Baldwin]

FY 2005 (COMPLIANCE)

þÿ D e c r e a s e u n d e r a g e d r i n k i n g m i d d l e s c h o
þÿ - T G f D r u g s - m i d d l e s c h o o l s
þÿ - S t a y i n g C o n n . w / Y o u r T e e n
þÿ - T G f D r u g s & V i o l e n c e - Y M C A
þÿ - P o s i t i v e A c t i o n / 2 d S t e p

þÿ - S t a y i n g C o n n . w / Y o u r T e e n

6th & 7th Graders
Parents
-6th & 7th Graders & Parents
- 6th & 7th Graders, siblings & parents

8. Cahaba Center
[Dallas, Perry, Wilcox]
þÿ - P e r r y C o u n t y P r e v e n t i o n C o a l i t i o n p a
compliance checks
þÿ - C l o s i n g t h e G a t e m o n i t o r & r e p o r t e x t
intervention -Life Skills & Life Skills for parents; Project Alert; T G f D; Closing the Gate K-5th; 7th & 8th (Perry County) & parents; 5-16 minus 6th Grade-Dallas & Wilcox Counties; male & female; Black/White/Hispanic, Asian; Other; 2000 participants targeted

9. CED MHC
[DeKalb, Cherokee, Etowah]

Decrease underage drinking in impoverished communities
-Continuum of care: during school; after school; summer months
þÿ - T G f D

þÿ - T G f D r u g s & V i o l e n c e

þÿ 1 s t 7 t h G r a d e r s

þÿ 1 s t 7 t h G r a d e r s

10 Gateway
[Jefferson, Blount, St. Claire]
Prevention during school -Alternative: 2x weekly after school; summer. Parent involvement - evenings 10-14 yr olds. Targeting 70 youth

11. Indian Rivers
[Bibb, Pickens, Tuscaloosa]
Reduce alcohol consumption by adults or children 10-12. Review laws/ordinances; data; implement media campaigns 3d, 4th, 5th graders: Aliceville

12. JCCEO
[Jefferson, Blount, St. Claire]
Reduce alcohol consumption; community action; develop youth groups; work w/ law enforcement; promote alcohol-free youth activities -Life Skills; STARR Ambassadors; After School 8th & 9th graders
11th graders

FY 2005 (COMPLIANCE)
þÿ 9 t h 1 2 t h g r a d e r s , s i b l i n g s , p a r e n t s

13. MHC of Madison C.
[Madison]
Enhance effectiveness of Educational Strategy through after school & summer activities

Decrease access & availability of alcohol to minors in specific zip code area

Mobilize community partners regarding underage drinking þÿ - K e e p i n i
-Parental education
-Life Skills
-Support Community Prevention Projects/activities 6th Graders
Parent involvement

14. Montgomery MH Authority
[Montgomery, Autauga, Lowndes, Elmore]]
Continue same goals/activities as previous year

15. Oakmont Center
[Jefferson, Blount, St. Claire]
Reduce underage drinking in specific community

-Life Skills (middle schools)
-Strengthening Families (community site) 6th & 8th Graders

16. Quest Recovery Ctr.
[Limestone, Lawrence, Morgan]
Increase ability of youth to resist ATOD usage through education; parent-child communication regarding ATOD; address improved decision-making & interpersonal competence; cultural awareness; promote opportunities to improve self-esteem; support peer bonding & improved academic performance; develop peer leaders; increase parent participation. Utilize media ATOD awareness campaigns During school, after school & summer activities Children of alcoholics/substance abusers, children w/ mental health problems; children w/ academic problems; children living in subsidized housing; children w/o fathers/mothers; rural youth

17. Riverbend
[Lauderdale, Colbert, Franklin]
-Community: þÿ D A & T B i n g o G a m e ; D r u g P r e v e
þÿ Y o u r s a c t i v i t y c a r d s Y M C A s u m m e r p r o g
þÿ J u s t S a y n o t o d r u g s
-Education: þÿ P r o j e c t 4 t h , 5th, & 6th grader. Youth under 12 yrs
-Children of: þÿ a l c o h o l i c s ; s u b s t a n c e u s e r s .
-Low performing academic youth; subsidized housing youth

18. UAB Prevention
[Jefferson, Blount, St. Claire]
Decrease arrest rates for drug & alcohol related charges in a specific community & after school settings. þÿ - T G f D
þÿ - T G f D r u g s & V i o l e n c e
-After School activities
-Community -5th to 7th graders
-9th & 10th Graders
-Jefferson County Family Court
-Youth 7-13 yrs

19. Wiregrass MH Board, Inc./ Spectracare

FY 2005 (COMPLIANCE)
[Dale, Geneva,, Henry, Barbour, Houston]
-Build & strengthen Prevention coalition
þÿ - R e d u c e a l c o h o l & t o b a c c o u s e a m o n g s p e c
County þÿ - T G f D r u g s
þÿ - T G f D r u g s & V i o l e n c e
þÿ D o t h a n L e i s u r e S e r v i c e s

þÿ - H . S . f a m i l y / c o n s u m e r s c i e n c e c l a s s e s
-K-8th graders
-Youth in after school & summer activities
-parents & caregivers
þÿ - 9 t h 1 2 t h g r a d e r s
20. Southwest AL MH/MR Board
[Clarke, Conecuh, Escambia, Monroe]
Decrease underage drinking, access & usage in specifically targeted county population. Increase youth access to SADD Chapter activities þÿ R a p D a y recreation
þÿ P a r e n t i n g W i s e l y & S O S
þÿ R e c o n n e c t i n g Y o u t h
þÿ R a i n b o w F - A t - r i s k t e e n s
-Parents & caregivers
-At-risk teens
-Parents & caregivers

21. Cheaha MHC
[Talladega, Clay, Randolph, Coosa]
Decrease underage alcohol use in specified community through publicity campaigns; partnering with organizations & groups educating parents/community; youth-oriented collaborative efforts
- County/city ordinance initiatives
þÿ - H e a l t h y l i f e s t y l e s
- Parent advocacy activities
- Community group activities
- Community
- School youth

22. Franklin Primary Health
[Mobile, Washington]
-Decrease the number of arrests for marijuana possession among youths in a specific community
-Target community norms -Collaborate with the Leflore and Murphy school nurses in health fairs to promote healthy and drug free lifestyles and with local area church groups to provide information and education concerning the risk of marijuana usage in youths
-Community
-Youth

23. Lighthouse Counseling
[Montgomery, Autauga, Lowndes, Elmore]
To prevent underage alcohol use in youth within a specific Community Center utilizing 100% environmental strategy
-Collaborate with specific county vendors
-Disseminate media messages
-Youth: 6-16 yrs old
-Targeting: 50 youth.

24. Marshall-Jackson MH/ Mountain Lakes MHC
[Marshall, Jackson]
-Target underage drinking issues & community attitudes regarding underage

drinking.
þÿ - S e n i o r s s u b s t a n c e u s e / a b u s e i s s u e s
þÿ - A l s P r o g r a m m o d e l
þÿ - H e r e , N o w , a n d D o w n t h e - Y o u t h a d P a r e n t p
- Parents

25. MH of Cullman
[Cullman]
-Decrease underage drinking and binge drinking
-Target community college ATOD school policy
Educational activities College youth

26. SAYNO
[Montgomery]
All Environmental strategies Media campaigns concentrated in high impoverished area of King Hill community, collaborating with Faith Based and Law Enforcement/ and overall practice change of vendors and community stakeholders

27. Northwest AL MH
[Fayette, Lamar, Marion,, Walker, Winston]
-Decrease risk factors
ATOD
Association with delinquent peers
Increase positive parental attitudes toward substances þÿ - T G f D
þÿ - T G f D & V i o l e n c e
þÿ - P r o j e c t A l e r t
þÿ - K e e p a C l e S c h o o l - M i d d l e Y o u t h
Parents

The Coalitions have been involved in numerous trainings on the Strategic Prevention Framework. These trainings are used as a springboard for offering a comprehensive and coordinated system of evidenced based prevention activities for reducing the incidence and affects of alcohol, tobacco, other drug abuse, þÿ a n d r e l a t e d y o u t h v i o l e n c e a m o n g t h e s t a the coalition efforts is to promote community and evidenced based prevention programs and practices, which take into account risk and protective factors, which include but are not limited to family enhancement, violence reduction, conflict resolution, AIDS/HIV, teen pregnancy, and other issues pertinent to the reduction of substance abuse.

The State Incentive Grant has funded 12 community-based coalitions that have utilized the technological training and support services through the Southeast Center for the Application of Prevention Technologies. Technical assistance and trainings have promoted the evidenced based prevention programs through closely working with the SECAPT staff and external training sessions. The following is a breakdown of each county coalition and the drug of choice reflected through the PRIDE survey data to show significant impact and influence among children and families.

þÿ S i x (6) c o u n t y c o a l i t i o n s a r e C a p a c i t y
exposed to in-depth training on their respective drug. Barbour, Wilcox, Dallas and Marshall Counties have concentrated efforts on Underage Drinking from using evidenced based curriculum in both school environments as well as in the community. Extensive media campaigns and collaboration with the Alabama Beverage Control Board personnel. Winston County has concentrated on high tobacco rates and Macon County has shown high incidences and reporting around marijuana usage.

The six (6) Implementation grantees under the State Incentive Grant are

FY 2005 (COMPLIANCE)
Montgomery, Mobile, Tuscaloosa, Talladega, Huntsville and Elmore counties. All of the Implementation grantees are utilizing evidenced based education (Life Skills, Too Good for Drugs, Communities Mobilizing for Change on Alcohol, Positive Action, Parenting Wisely, Project Alert, Not on Tobacco, Too Good for Violence and Second Step.
þÿ M a n y o f t h e I m p l e m e n t a t i o n u t i l i z e s A l t e
and Environmental Strategies to mobilize the community efforts.

Problem Identification & Referral was not a strategies funded under the Block grant or the State Incentive Grant.

FY 2007 (PROGRESS)
PROGRESS 2007

A prevention process has been adapted to continue efforts to coordinate prevention activities in order to eliminate duplication and promote accountability of community based prevention programs in the sixty-seven (67) county catchment area. Also, the state has begun an implementation process to collect, compile and address reporting demographic data which meets the requirements set forth by CSAP. The Office of Prevention has attempted to strengthen interagency cooperation through monthly meetings with state partners þÿ u n d e r t h e g u i s e o f t h e G o v e r n o r s A d v i s o of the Department of Education, Department of Public Health, Girl Scouts of þÿ A l a b a m a , D e p a r t m e n t o f Y o u t h S e r v i c e s , D Department of Human Resources and the Alabama Department of Economic and Community Affairs. The following agreed upon goals have been captured to strengthen prevention services through statewide collaboration.
1) Promote a general understanding of how prevention and healthy children and family service have a need to co-exist in a system of care.
2) þÿ P r o m o t e a n d u n d e r s t a n d t h a t a s h a r e d o strengths toward targeted prevention goals.
3) Hard evidence and facts attained through data obtained from a community needs assessment must always be at the forefront of planning.
4) Community trends, patterns, environmental signs and history are important elements to drive change and sustain positive outcomes.
5) A shared vision for Coalition Development must provide avenues for networking and connectedness to facilitate strong goals and objectives.
6) Assets building are a link in all planning processes.
7) All successes (large and small) shall be documented and publicized for community input and buy-in.

The Office of Prevention has requested the Southeast Center for the Application of Prevention Technologies to facilitate assessments with the State Incentive Grantees that will mirror the above process with the Block Grant providers. Outcome oriented services are evolving to mobilize efforts in communities with existing partners. This initiative has received support from our Department of Education state partners and the formulation of the Alabama Epidemiological Outcomes Workgroup (AEOW). The deliverables under the AEOW will begin process to connect with various state partners whom catalog data in many different categories. The PRIDE survey that is utilized by community providers and the Department of Education has proven successful as a barometer to gauge efforts in prevention programs and practices in the community as well as the state office. The Office of Prevention finally hired an Epidemiologist in the beginning of the calendar year of 2007. This change in staff is viewed as a major milestone to change the face of prevention services from the state and community prospective.

FY 2008 (INTENDED USE)
INTENDED USE 2008

All state prevention services are located in the following areas of the state. The following Counties designate the name and locations of areas for service provision:

Counties	Provider
Lauderdale, Colbert, Franklin	Riverbend Mental Health Center
Limestone, Lawrence, Morgan	Mental Health Center of North Central
Madison	Huntsville-Madison Co. MHC
Fayette, Lamar, Marion, Walker, Winston	Northwest AL MHC
Jefferson, Blount, St. Clair	Alethia House Inc, ARS, Gateway JCCEO, Oakmont, Univ. of Alabama
Dekalb, Cherokee, Etowah	CED MHC, Cherokee County SA Council
Calhoun, Cleburne	Agency for Substance Abuse Prevention
Bibb, Pickens, Tuscaloosa	Indian Rivers MHC
Talladega, Clay, Randolph, Coosa	Cheaha MHC
Choctaw, Greene, Hale, Marengo, Sumter	West Alabama MHC
Chilton, Shelby	Chilton Shelby MHC
Chambers, Lee, Tallapoosa, Russell	East Alabama MHC
Dallas, Perry, Wilcox	Cahaba Center for Mental Health
Montgomery, Autauga, Lowndes, Elmore	Council on Substance Abuse Lighthouse, SAYNO
Macon, Pike, Bullock	East Central MHC
Mobile, Washington	Drug Education Council Franklin Primary
Clarke, Conecuh, Escambia, Monroe	Southwest AL MHC
Dale, Geneva, Henry, Barbour, Houston	Wiregrass MHC
Jackson, Marshall	Mountain Lakes Behavioral Health Care
Baldwin	Baldwin County MHC

FY 2008 (INTENDED USE)

Cullman Cullman MH Authority
North Central SA Council

The Mental Health Centers are responsible for the planning of services for consumers in the community. Due to the monetary allocations of the Block grant, prevention initiatives do not exist in every county. This is one of the overall objectives of the Office of Prevention to develop a plan to support further coalition development and sustainability efforts in conjunction with the twelve coalitions supported by State Incentive Grant dollars. An þÿ o r g a n i z a t i o n a l a n d c o l l a b o r a t i v e b r i d g e is necessary to build infrastructure around personnel and stakeholder expertise. The Office of Prevention overall program goals and objectives are to 1) Reduce the level of risk for problem behaviors in youth by improving community standards, codes and practices-via to promote healthy beliefs and clear standards concerning the use of alcohol, tobacco and other drugs by youth through the use of environmental approaches. 2) Improve the overall community awareness in the state by providing knowledge about the use of alcohol, tobacco and other drugs-via educational programming regarding the use of alcohol, tobacco and other drugs and the hazards of their use through information dissemination strategies. The Office of Prevention will support the development of policy and practice campaigns for non-favorable attitudes toward use. The þÿ c o m m u n i t y s a b i l i t y t o e n h a n c e t h e a b i l i services to those of all ages is paramount to the success of the continuum of care for substance services. Lastly, the Office of Prevention is working toward to improve the planning, organization and effectiveness of alcohol, tobacco and other drug use prevention services in the community with mobilization efforts individualized to community culture and strategies. To facilitate these goals, the Office of Prevention will hire four statewide positions designated as Prevention Consultants by the end of the first quarter of the fiscal year. The expansion of technical assistance to community stakeholders will occur. In addition, the state will be able to build an infrastructure around training and staff development issues. The geographic locations of the consultants will cover the state in regions. The regions will be developed on the actual size, allocation and infrastructure needs of the provider and capability and expertise of the Prevention Consultants. All Prevention Consultants are hired on a contractual basis.

State:
Alabama

Attachment A: Prevention

Answer the following questions about the current year status of policies, procedures, and legislation in your State. Most of the questions are related to Healthy People 2010 objectives. References to these objectives are provided for each application question. To respond, check the appropriate box or enter numbers on the blanks provided. After you have completed your answers, copy the attachment and submit it with your application.

1. Does your State conduct sobriety checkpoints on major and minor thoroughfares on a periodic basis? (HP 26-25)

☒ Yes ☐ No ☐ Unknown

2. Does your State conduct or fund prevention/education activities aimed at preschool children? (HP 26-9)

☒ Yes ☐ No ☐ Unknown

3. Does your State alcohol and drug agency conduct or fund prevention/education activities in every school district aimed at youth grades K-12? (HP 26-9)

SAPT BLOCK GRANT	OTHER STATE FUNDS	DRUG FREE SCHOOLS
☒ Yes	☐ Yes	☒ Yes
☐ No	☒ No	☐ No
☐ Unknown	☐ Unknown	☐ Unknown

4. Does your State have laws making it illegal to consume alcoholic beverages on the campuses of State colleges and universities? (HP 26-11)

☒ Yes ☐ No ☐ Unknown

5. Does your State conduct prevention/education activities aimed at college students that include: (HP 26-11c)

Education Bureau? ☒ Yes ☐ No ☐ Unknown

Dissemination of materials? ☒ Yes ☐ No ☐ Unknown

Media campaigns? ☒ Yes ☐ No ☐ Unknown

Product pricing strategies? ☒ Yes ☐ No ☐ Unknown

Policy to limit access? ☒ Yes ☐ No ☐ Unknown

6. Does your State now have laws that provide for administrative suspension or revocation of drivers' licenses for those determined to have been driving under the influence of intoxicants? (HP 26-24)

☒ Yes ☐ No ☐ Unknown

Page 34 of 240

7. Has the State enacted and enforced new policies in the last year to reduce access to alcoholic beverages by minors such as: (HP 26-11c, 12, 23)

Restrictions at recreational and entertainment events at which youth made up a majority of participants/consumers,

☐ Yes ☒ No ☐ Unknown

New product pricing,

☐ Yes ☒ No ☐ Unknown

New taxes on alcoholic beverages,

☐ Yes ☒ No ☐ Unknown

New Laws or enforcement of penalties and license revocation for sale of alcoholic beverages to minors,

☐ Yes ☒ No ☐ Unknown

Parental responsibility laws for a child's possession and use of alcoholic beverages.

☐ Yes ☒ No ☐ Unknown

8. Does your State provide training and assistance activities for parents regarding alcohol, tobacco, and other drug use by minors?

☒ Yes ☐ No ☐ Unknown

9. What is the average age of first use for the following? (HP 26-9 and 27-4) (if available)

	Age 0 - 5	Age 6 - 11	Age 12 - 14	Age 15 - 18
Cigarettes	☐	☒	☐	☐
Alcohol	☐	☒	☐	☐
Marijuana	☐	☐	☒	☐

10. What is your State's present legal alcohol concentration tolerance level for: (HP 26-25)

Motor vehicle drivers age 21 and older? .08

Motor vehicle drivers under age 21? .02

11. How many communities in your State have comprehensive, community-wide coalitions for alcohol and other durg abuse prevention (HP 26-3)? 4

12. Has your State enacted statutes to restrict promotion of alcoholic beverages and tobacco that are focused principally on young audiences (HP 26-11 and 26-16)?

☐ Yes ☒ No ☐ Unknown

Alabama

Goal #3: Pregnant Women Services

GOAL # 3. An agreement to expend not less than an amount equal to the amount expended by the State for FY 1994 to establish new programs or expand the capacity of existing programs to make available treatment services designed for pregnant women and women with dependent children; and, directly or through arrangements with other public or nonprofit entities, to make available prenatal care to women receiving such treatment services, and, while the women are receiving services, child care (See 42 U.S.C. 300x-22(b)(1)(C) and 45 C.F.R. 96.124(c)(e)).

FY 2005 (Compliance):

FY 2007 (Progress):

FY 2008 (Intended Use):

FY 2005 (COMPLIANCE)
GOAL #3. The Substance Abuse Services Division will allocate $2,556,405 for treatment services designed for pregnant women and women with dependent children and, directly or through arrangements with other public or nonprofit private entities, make available prenatal care to women receiving such treatment services, and, while the women are receiving services, child care, transportation, case management and outreach services.

Objective: Services designed for pregnant women and women with dependent children increased equal to the amount contracted in accordance with Block Grant set-aside requirements. Prenatal care is available either directly or through arrangements with other public or nonprofit private entities. While the women are receiving services childcare, transportation, case management and outreach services are also available.

FFY 2005 (Compliance):

Result: Accomplished. $2,556,405 was spent for services for pregnant women and women with dependent children.

FY 2007 (PROGRESS)
FFY 2007 (Progress):

Activity: Identify $2,556,405 of the Block Grant for the provision of specific services to pregnant women and women with dependent children.

Current Status: $2,556,405 has been put into contracts with community treatment providers specifically for services for pregnant women and women with dependent children.

Activity: Identify the services that are to be purchased with the funding for special women's services.

Current Status: Specific services have been defined, valued and included in the Billing Manual.

Activity: Specify this funding by creating separate funding and service codes.

Current Status: Separate service codes have been established.

Activity: Enter into contracts for the provision of the specified services.

Current Status: Funds have been obligated appropriately.

Activity: Monitor service provision through the normal contracting and service reporting systems.

Current Status: Contracts for special women¿s services are being monitored in the same system as all other community contracts through the Substance Abuse Services Division.

FY 2008 (INTENDED)
FFY 2007 (Intended Use):

Activity: Identify $2,556,405 of the Block Grant for the provision of specific services to pregnant women and women with dependent children.

Activity: Identify the services that are to be purchased with the funding for special women's services.

Activity: Specify this funding by creating separate funding and service codes.

Activity: Enter into contracts for the provision of the specified services.

Activity: Monitor service provision through the normal contracting and service reporting systems.

It is planned in FY 2008 for the Alabama Substance Abuse Services Division to support three residential programs and nine outpatient programs specifically designed for pregnant women and women with dependent children. These programs will accept priority admissions from all around the state. Each program is described below.

A. Residential Programs:

The Aletheia House in Birmingham provides supportive housing to meet the unique needs of pregnant addicted women. While living in this housing the women attend sixty days of intensive outpatient treatment and are also provided prenatal care and special instruction on nutrition, health care, basic education, parenting, the development of daily living skills and are transported to support group meetings. The women are allowed to remain in the pregnancy program for up to three months after the birth of the baby. Special rooms are provided for mother and child. Olivia¿s House, a branch of the Alcohol and Drug Abuse Treatment Centers, Inc., is also in Birmingham and the Freedom House in Rogersville provide residential care for addicted women and their children. In addition to the treatment services prenatal care, special instruction on nutrition, healthcare, basic education, parenting, and the development of daily living skills and transportation are provided.

B. Outpatient Programs:

Intensive, gender specific outpatient services are offered in the programs listed below. In addition to these treatment services other services are offered including, but not limited to, medical care, child care, case management, educational services, vocational services, and transportation.

Bibb, Pickens, Tuscaloosa Mental Health Center, Tuscaloosa
Cahaba Center for Mental Health, Selma
Mobile Mental Health Center, Mobile
Lighthouse Counseling Center, Montgomery
North Central Mental Health Center, Decatur
Southwest Alabama Mental Health Center, Monroeville
University of Alabama at Birmingham, Drug Free Clinic, Birmingham
East Alabama Mental Health Center, Opelika
Riverbend Center for Mental Health, Florence

Other Programs exclusively designed to meet the special needs of addicted women are: St. Anne's Home a half-way house program, Indian Rivers crisis residential program, Second Choices program in Mobile, and Emma's Harvest Home in Mobile. All of the previously described programs are certified non-profit community programs. The services are purchased through fee-for-service contracts.

FY 2008 (INTENDED)

The statewide waiting list for residential treatment will be continued. This information is compared to the number of bed days required for residential treatment and the number of beds allocated to women by the program description of each of our providers of residential services. These methods provide an estimate of treatment capacity and utilization. Pregnant women are given a priority status on waiting lists.

Careful study of the methods mentioned above to monitor the adequacy of efforts to meet the special needs of women and to estimate capacity and utilization by women will be the resource for identifying areas for potential improvement. A workgroup has been created to make recommendations for improvements in services to pregnant women, women and women with children. Changes are scheduled to begin during SFY 2007-08 and will be reported in the 2009 Block Grant Application.

Alabama

Attachment B: Programs for Women

Attachment B: Programs for Pregnant Women and Women with Dependent Children
(See 42 U.S.C. 300x-22(b); 45 C.F.R. 96.124(c)(3); and 45 C.F.R. 96.122(f)(1)(viii))

For the fiscal year three years prior (FY 2005) to the fiscal year for which the State is applying for funds:
Refer back to your Substance Abuse Entity Inventory (Form 6). Identify those projects serving pregnant women and women with dependent children and the types of services provided in FY 2005. In a narrative of up to two pages, describe these funded projects.

Attachment B: Programs for Pregnant Women and Women with Dependent Children.

Part I: Description of Services Provided in FFY 2005.

1. The following programs are listed on FORM 06.

NFR ID# AL750405	Alcoholism Recovery Service, Birmingham	$ 828,637
NFR ID# AL300037	Aletheia House, Birmingham	330,004
NFR ID# AL900091	Bibb, Pickens, Tuscaloosa,	111,541
NFR ID# AL302108	Cahaba MHC, Selma	157,999
NFR ID# AL900612	East Alabama MHC, Opelika	134,838
NFR ID# AL301407	Lighthouse Counseling, Montg.	134,963
NFR ID# AL901206	Mobile MHC, Mobile	119,230
NFR ID# AL900117	North Central MHC, Decatur	209,507
NFR ID# AL900513	Southwest MHC, Monroeville	101,787
NFR ID# AL100668	SA Council NW AL	99,640
NFR ID# N/A	Freedom House, Rogersville	97,985
NFR ID# AL900778	Riverbend MHC, Florence	184,800
NFR ID# AL100049	UAB, Birmingham	143,753
Total		$ 2,654,684

In the 1997 Block Grant Application, FORM 06, the Entity Inventory included the programs as identified previously. The only program that provided services that qualified to be considered Special Services for Pregnant Women and Women with Dependent Children¿ prior to SFY 1996-97 was Aletheia House, NFR ID # AL 300037. Aletheia House received $92,200 for the provision of residential services to pregnant women and women with dependent children, although this was not the only service Aletheia House provided. This $92,200 provided to Aletheia House established the base upon which Special Services to Pregnant Women and Women with Dependent Children were expanded.

The Aletheia House in Birmingham provides supportive housing to meet the unique needs of pregnant addicted women. While living in this housing the women attend sixty days of intensive outpatient treatment and are also provided prenatal care and special instruction on nutrition, health care, basic education, parenting, the development of daily living skills and are transported to support group meetings. The women are allowed to remain in the pregnancy program for up to three months after the birth of the baby. Special rooms are provided for mother and child.

1. The data for programs for FY 2005 are above.

2. Alabama ensured compliance with Section 1916 (c) (14) by funding these programs, and by exploring implementation of additional services.

3. The State monitored the programs through on-site visits, evaluation of the service data submitted and through the statewide waiting list for residential treatment. In addition, a Women¿s Services Task Group was established to keep abreast of innovative treatment methods, effective outreach and retention for women in treatment as well as effective prevention programs for women. The Task Group, consisting of treatment providers, prevention providers, and state personnel, also functioned as an advisory committee to the SASD.

4. The SASD established a statewide waiting list for residential treatment. This information is compared to the number of bed days required in residential treatment and the number of beds allocated to women by the program description of each of our providers of residential services. These methods provide an estimate of treatment capacity and utilization. Pregnant women are given a priority status on waiting lists.

5. The State created a priority treatment rating scale establishing pregnant

women as a number one priority and women with dependent children as a number two priority to assure access to treatment for these women.

Alabama

Attachment B: Programs for Women (contd.)

The PHS Act required the State to expend at least 5 percent of the FY 1993 and FY 1994 block grants to increase (relative to FY 1992 and FY 1993, respectively) the availability of treatment services designed for pregnant women and women with dependent children. In the case of a grant for any subsequent fiscal year, the State will expend for such services for such women not less than an amount equal to the amount expended by the State for fiscal year 1994.

In up to four pages, answer the following questions:

1. Identify the name, location (include sub-State planning area), Inventory of Substance Abuse Treatment Services (I-SATS) ID number (formerly the National Facility Register (NFR) number), level of care (refer to definitions in Section II.4), capacity, and amount of funds made available to each program designed to meet the needs of pregnant women and women with dependent children.

2. What did the State do to ensure compliance with 42 U.S.C. 300x-22(b)(1)(C) in spending FY 2005 block grant and/or State funds?

3. What special methods did the State use to monitor the adequacy of efforts to meet the special needs of pregnant women and women with dependent children?

4. What sources of data did the State use in estimating treatment capacity and utilization by pregnant women and women with dependent children?

5. What did the State do with FY 2005 block grant and/or State funds to establish new programs or expand the capacity of existing programs for pregnant women and women with dependent children?

Alabama

Goal #4: IVDU Services

GOAL # 4. An agreement to provide treatment to intravenous drug abusers that fulfills the 90 percent capacity reporting, 14-120 day performance requirement, interim services, outreach activities and monitoring requirements (See 42 U.S.C. 300x-23 and 45 C.F.R. 96.126).

FY 2005 (Compliance):

FY 2007 (Progress):

FY 2008 (Intended Use):

Page 45 of 240

FY 2005 (COMPLIANCE)
FFY 2005 (Compliance):

Result: Accomplished. The goal was met by continuing to operate the Treatment Access Project (T.A.P.), as described in Narrative #9.

FY 2007 (PROGRESS)
FFY 2007 (Progress):

Activity: The Treatment Access Project (T.A.P.), as described in Narrative #9 of this application, will be continued. Access to treatment through the T.A.P. is driven by the priorities set by the Block Grant. The major components of T.A.P. include capacity management and waiting list management.

Current Status: The T.A.P. was continued.

Activity: Training will continue to be provided for service providers regarding T.A.P. and the Block Grant requirements.

Current Status: Training is being continued.

Activity: On-site technical assistance regarding T.A.P. will be made available to all service providers.

Current Status: On-site technical assistance is being provided.

Activity: Contract activity will be monitored by "desk audits".

Current Status: All vouchers and accompanying data are reviewed by a contracts manager prior to payment.

FY 2008 (INTENDED)
FFY 2008 (Intended Use):

Activity: The Treatment Access Project (T.A.P.), as described in Narrative #9 of this application, will be continued. Access to treatment through the T.A.P. is driven by the priorities set by the Block Grant. The major components of T.A.P. include capacity management and waiting list management.

Activity: Training will continue to be provided for service providers regarding T.A.P. and the Block Grant requirements.

Activity: On-site technical assistance regarding T.A.P. will be made available to all service providers.

Activity: Contract activity will be monitored by "desk audits".

To enter any substance abuse treatment program in Alabama the a person must first meet the clinical criteria for psychoactive substance abuse or dependence contained in the current edition of the Diagnostic and Statistical Manual of Mental Disorders. Priorities are given to clients as follows: 1) Pregnant Women, 2) Women with Dependent Children, 3) Injectable Drug User (6-month history of injectable drug use and use of injectable drug within last 30 days.), 4) Psychoactive Substance Dependence, Severe, 5) Psychoactive Substance Dependence Moderate, 6) Psychoactive Substance Dependence, Mild, and 7) Psychoactive Substance Abuse.

All treatment programs in Alabama are certified through the SASD. The Office of Certification conducts the programmatic certification. This process includes client record review for adequacy of care and program review for compliance.

All contracts developed by the SASD include a prohibition regarding the distribution of sterile needles and a prohibition of the provision of AIDS testing without appropriate pre-test and post-test counseling.

All contracts developed by the SASD include a provision requiring that the State be notified when an IVDU program reaches 90 percent of its capacity. In addition, the Treatment Access Project provides a single point within the State for information regarding available services, capacity of those services as well as the level of current capacity of those services. The Treatment Access Project allows for the review of the length of wait for admittance. It is through the analysis of the central waiting list and the admission data that the State is assured that IVDU¿s are admitted for service within specified periods.

All contracts developed by the SASD include a requirement that all programs conduct outreach activities for IVDUs.

Alabama

Attachment C: Programs for IVDU

Attachment C: Programs for Intravenous Drug Users (IVDUs)
(See 42 U.S.C. 300x-23; 45 C.F.R. 96.126; and 45 C.F.R. 96.122(f)(1)(ix))

For the fiscal year three years prior (FY 2005) to the fiscal year for which the State is applying for funds:

1. How did the State define IVDUs in need of treatment services?

2. 42 U.S.C. 300x-23(a)(1) requires that any program receiving amounts from the grant to provide treatment for intravenous drug abuse notify the State when the program has reached 90 percent of its capacity. Describe how the State ensured that this was done. Please provide a list of all such programs that notified the State during FY 2005 and include the program's I-SATS ID number (See 45 C.F.R. 96.126(a)).

3. 42 U.S.C. 300x-23(a)(2)(A)(B) requires that an individual who requests and is in need of treatment for intravenous drug abuse is admitted to a program of such treatment within 14-120 days. Describe how the State ensured that such programs were in compliance with the 14-120 day performance requirement (See 45 C.F.R. 96.126(b)).

4. 42 U.S.C. 300x-23(b) requires any program receiving amounts from the grant to provide treatment for intravenous drug abuse to carry out activities to encourage individuals in need of such treatment to undergo treatment. Describe how the State ensured that outreach activities directed toward IVDUs was accomplished (See 45 C.F.R. 96.126(e)).

Attachment C: Programs for Intravenous Drug Users (IVDUs)

All contract service providers are required to notify the SASD when 90% capacity is reached. No contracting service providers have reported reaching 90% of their capacity. The SASD is implementing an automated waiting list process as part of the screening, assessment, enrollment and level of care determination management system which will automatically identify program capacity. The expectation is that there will be programs that reach 90% of their capacity and appropriate action and assistance will be provided at that time.

Alabama

Attachment D: Program Compliance Monitoring

Attachment D: Program Compliance Monitoring
(See 45 C.F.R. 96.122(f)(3)(vii))

The Interim Final Rule (45 C.F.R. Part 96) requires effective strategies for monitoring programs' compliance with the following sections of the PHS Act: 42 U.S.C. 300x-23(a); 42 U.S.C. 300x-24(a); and 42 U.S.C. 300x-27(b).

For the fiscal year two years prior (FY 2006) to the fiscal year for which the State is applying for funds:

In up to three pages provide the following:

- A description of the strategies developed by the State for monitoring compliance with each of the sections identified below; and
- A description of the problems identified and corrective actions taken:

1. Notification of Reaching Capacity 42 U.S.C. 300x-23(a)
   (See 45 C.F.R. 96.126(f) and 45 C.F.R. 96.122(f)(3)(vii));

2. Tuberculosis Services 42 U.S.C. 300x-24(a)
   (See 45 C.F.R. 96.127(b) and 45 C.F.R. 96.122(f)(3)(vii)); and

3. Treatment Services for Pregnant Women 42 U.S.C. 300x-27(b)
   (See 45 C.F.R. 96.131(f) and 45 C.F.R. 96.122(f)(3)(vii)).

Attachment D: Program Compliance Monitoring.

1. Description of Strategies:

A. IVDU:

The following statement is included in each contract issued by the SASD.

Programs designed specifically for treating injectable drug users agree:

1. To notify SASD, DMH/MR any time 90% capacity is reached.
2. Assist SASD, DMH/MR to ensure that all injectable drug users requesting treatment shall be enrolled within 14 days if a program has beds available or within 120 days if no beds are available and to provide interim services with 48 hours of service request.
3. To carry out outreach activities to encourage injectable drug users to seek help.

Verification of completion of the terms of the contract is accomplished in three ways: 1) Certification site visits performed annually by the Office of Substance Abuse Certification, 2) Monthly desk reviews and contract compliance audits performed by the Office of Contracts, and 3) Annual analyses of the Waiting Lists which identifies clients by priority code length of wait.

B. Tuberculosis Counseling, Testing, and Treatment.

Compliance with Section 1924 (a) was achieved by including in the Alabama Substance Abuse Program Standards a requirement which states that each program shall demonstrate that it provides tuberculosis counseling, testing, and treatment for each person entering substance abuse treatment, either directly by the agency or indirectly by another provider. Before an agency can be licensed (certified) to provide treatment services, it must come into compliance with the standards. All agencies that receive block grant funds through the SASD contract must be certified before they can be considered for a contract. Monitoring for compliance is a function of the Office of Substance Abuse Certification through its annual certification site visits.

C. Treatment Services for Pregnant Women.

Each pregnant woman who seeks or is referred for, and would benefit from treatment services, is given preference in admissions. Pregnant women are listed as the first priority for treatment in the contract with treatment providers. Referrals of pregnant women who cannot immediately be served are handled through the Treatment Access Project¿s Waiting List. It is the responsibility of the staff who maintains the waiting list to place the pregnant woman into the next available treatment slot. Where residential services are needed, and immediate entry into treatment cannot be gained, interim intensive outpatient services are made available through the nearest treatment provider.

2. Description of the Problems Identified and Corrective Actions Taken.

A. Capacity of IVDU Treatment Programs:

To date no treatment agency has officially informed SASD of their inability to serve this population as required by contract. Site certification visits performed annually by the Office of Substance Abuse Certification, contract compliance audits performed by the SASD, and analyses of the Waiting List data have not revealed any discrepancies in this section of the contract for any provider of IVDU treatment services.

B. Tuberculosis Counseling, Testing, and Treatment.

The anticipated added costs involved in testing and treating all substance abuse treatment clients posed the greatest challenge to implementation of this requirement. SASD met the challenge through the development of a cooperative relationship with the Alabama Public Health Department, whereby the county health departments supply the serum and needles to treatment agencies that have nurses assigned and provide the testing for agencies that do not have nurses assigned. SASD treatment agencies complete the counseling, testing (where nurses are available), required documentation, and make referrals for chest X-rays and tuberculosis treatment as needed. Public Health provides X-rays, medications, and statistical analysis for the program. In addition, the county health departments and treatment agencies work cooperatively to administer the medication for the required period of treatment. Once the cooperative agreement was worked out, a five-person team, composed of representatives of SASD and Public Health toured the state, providing guidance and implementing instructions to all organizations involved in the project. After one full year of operation the glitches were worked out and the system was fully erational.

Modifications have been made to Alabama's approach to T.B. testing based on data collected by the Department of Public Health. October 1, 1993, to September 30, 1995, the Department of Public Health screened 13,556 substance abuse clients for T.B. A total of two new cases of T.B. were discovered. The Department of Public Health recommended that due to the very low number of new cases and the very high cost of testing every admission that Alabama cut back on the requirement for testing all admissions and provide T.B. test only to those clients exhibiting symptoms.

The Alabama Substance Abuse Services Division implemented a policy beginning October 1, 1995, requiring that intake clinicians observe and refer only those clients showing symptoms of T.B. for testing at their local health partments.
Since the implementation of the change beginning in October 1995, most of the community programs are only testing the clients that show symptoms of T.B., however, some of the programs still test all admissions and provide testing on site using trained staff. It is the professional opinion of the staff with the Alabama Health Department and the substance abuse community treatment programs that the current approach will adequately detect T.B. clients receiving substance abuse treatment.

Treatment Services for Pregnant Women:

During SFY 2004-2005, 44 pregnant women were put on waiting lists for admission to residential treatment programs, 18 or 40.91% were admitted for treatment. During this same year 660 women with dependent children were put on waiting lists for admission to residential treatment programs, 321 or 48.64% were admitted for treatment. The average waiting period for crisis residential admission for the SFY 2004-2005 was 27.25 days and 11.97 days for residential rehabilitation.

There is no waiting list for intensive outpatient services. This has allowed us to expedite pregnant women ahead of all others or to provide interim intensive outpatient services in order to fulfill the block grant requirements.

Alabama

Goal #5: TB Services

GOAL # 5. An agreement, directly or through arrangements with other public or nonprofit private entities, to routinely make available tuberculosis services to each individual receiving treatment for substance abuse and to monitor such service delivery (See 42 U.S.C. 300x-24(a) and 45 C.F.R. 96.127).

FY 2005 (Compliance):

FY 2007 (Progress):

FY 2008 (Intended Use):

Page 54 of 240

FY 2005 (COMPLIANCE)
GOAL #5. The Substance Abuse Services Division will directly or through arrangements with other public or nonprofit private entities, routinely make available tuberculosis services to each individual receiving treatment for substance abuse when observed symptoms indicate (see Attachment E).

Objective: In conjunction with the Alabama Department of Public Health all clients admitted for substance abuse treatment will be tested for T.B. when symptoms are observed indicating the need for a test.

FFY 2005 (Compliance):

Result: Accomplished. The process as established and described in Attachment E was continued. However, based on data collected by the Public Health Department, the process was modified beginning October 1, 1995. Data collected by the Health Department indicated that the previous practice of giving a skin test to each client who was admitted for substance abuse treatment was not necessary. The new procedure allows for skin tests to be conducted on clients that have been identified through observation of symptoms as needing the skin test.

FY 2007 (PROGRESS)
FFY 2007 (Progress):

Activity: The process established with the Alabama Department of Public Health, as described in Attachment E of this application, will be continued.

Current Status: The process as described in Attachment E is being continued.

Activity: Monitoring of the effectiveness of the process will be done through on-site visits with service providers.

Current Status: The effectiveness of the process is being monitored both by the SASD and the Public Health Department.

FY 2008 (INTENDED)
FFY 2008 (Intended Use):

Activity: The process established with the Alabama Department of Public Health, as described in Attachment E of this application, will be continued.

Activity: Monitoring of the effectiveness of the process will be done through on-site visits with service providers.

All substance abuse treatment programs will screen admissions for symptoms of T.B. Identified clients will be tested by qualified program staff, if available, or be referred to the local County Health Department.

Alabama

Goal #6: HIV Services

GOAL # 6. An agreement, by designated States, to provide treatment for persons with substance abuse problems with an emphasis on making available within existing programs early intervention services for HIV in areas of the State that have the greatest need for such services and to monitor such service delivery (See 42 U.S.C. 300x-24(b) and 45 C.F.R. 96.128).

FY 2005 (Compliance):

FY 2007 (Progress):

FY 2008 (Intended Use):

FY 2005 (COMPLIANCE)
GOAL #6. The Substance Abuse Services Division will contract for the provision of treatment for persons with substance abuse problems with emphasis on making available within existing programs early intervention services for HIV in areas of the State that have the greatest need for such services and will monitor such service delivery.

Objective: Early intervention services for HIV will be made available in the areas of greatest need.

FFY 2005 (Compliance):

Result: Accomplished. Contracts were implemented in nine of the Mental Health Catchment Areas of the state with the highest HIV positivity rate per 100,000 population. The contracts were monitored and appropriate services were provided.

FY 2007 (PROGRESS)
FFY 2007 (Progress):

Activity: The HIV services defined in the Billing Manual will be provided through contract.

Current Status: Accomplished.

Activity: Reimbursement rates as specified in the Billing Manual will be used to reimburse community providers.

Current Status: Accomplished.

Activity: Contracts will be developed to facilitate the provision of the specified early intervention services in the areas of the state with the greatest need.

Current Status: Accomplished.

Activity: 5% of the Block Grant award will be made available, through community contracts, to provide Early Intervention Services for HIV. The services will be targeted to areas of the State with the highest rate of HIV positivity.

Current Status: Accomplished.

Activity: All HIV early intervention services will be monitored through the same specific coding and reporting system as all other services purchased by the Substance Abuse Services Division.

Current Status: Accomplished.

Activity: The certification standards requiring that all certified programs provide each client HIV risk education including prevention information will be enforced.

Current Status: Accomplished.

FY 2008 (INTENDED)
FFY 2008 (Intended Use):

Activity: The Contract Billing Manual will include HIV Early Intervention Services that are determined to be the most appropriate for Alabama. The Services will be developed and defined in conjunction with the Alabama Department of Public Health, HIV/AIDS Division utilizing guidance from the Center for Disease Control (CDC) and the Center for Substance Abuse Treatment (CSAT).

Activity: Reimbursement rates as specified in the Billing Manual will be used to reimburse community providers.

Activity: Contracts will be developed to facilitate the provision of the specified early intervention services in the areas of the state with the greatest need.

Activity: $1,188,359 will be made available, through community contracts, to provide Early Intervention Services for HIV. The services will be targeted to areas of the State with the highest rate of HIV positivity.

Activity: All HIV early intervention services will be monitored through the same specific coding and reporting system as all other services purchased by the Substance Abuse Services Division.

Activity: The certification standards requiring that all certified programs provide each client HIV risk education including prevention information will be enforced.

Contracts are in effect for HIV Early Intervention Services with the following providers.

M-13	Cahaba Mental Health Center, Selma	$ 100,000
M-14	Chemical Addictions Program, Montgomery	95,365
M-15	East Central Mental Health Center, Troy	4,325
M-16	Mobile Mental Health Center, Mobile	267,000
M-3	Huntsville-Madison Mental Health Center, Huntsville	15,575
M-5	Alcoholism Recovery Service, Birmingham	375,000
M-5	UAB Substance Abuse Program, Birmingham	238,000
M-14	Lighthouse Counseling Center, Montgomery	100,000
M-9	Cheaha Mental Health Center	75,000
	Total	$1,270,265

The contracts are fee-for-service and the providers are certified through the SASD.

Goal #6: HIV Services Footnotes
The SASD is working with the Alabama Department of Public Health to develop strategies to coordinate HIV Early Intervention (including testing) and substance abuse treatment to maximize effectiveness and efficiency. The goal is to identify the appropriate role for each department, including financial resources, to assure that accessible, appropriate services are available in as many locations as possible. The SASD has not ruled out the use of SAPT Block Grant funds for the implementation of rapid HIV testing technology, but will follow the lead of the Public Health Department.

Alabama

Attachment E: TB and Early Intervention Svcs

Attachment E: Tuberculosis (TB) and Early Intervention Services for HIV
(See 45 C.F.R. 96.122(f)(1)(x))
For the fiscal year three years prior (FY 2005) to the fiscal year for which the State is applying for funds:
Provide a description of the State's procedures and activities and the total funds expended (or obligated if expenditure data is not available) for tuberculosis services. If a "designated State," provide funds expended (or obligated), for early intervention services for HIV.

Examples of procedures include, but are not limited to:

- development of procedures (and any subsequent amendments), for tuberculosis services and, if a designated State, early intervention services for HIV, e.g., Qualified Services Organization Agreements (QSOA) and Memoranda of Understanding (MOU);

- the role of the single State authority (SSA) for substance abuse prevention and treatment; and

- the role of the single State authority for public health and communicable diseases.

Examples of activities include, but are not limited to:

- the type and amount of training made available to providers to ensure that tuberculosis services are routinely made available to each individual receiving treatment for substance abuse;

- the number and geographic locations (include sub-State planning area) of projects delivering early intervention services for HIV;

- the linkages between IVDU outreach (See 42 U.S.C. 300x-23(b) and 45 C.F.R. 96.126(e)) and the projects delivering early intervention services for HIV; and

- technical assistance.

Page 63 of 240

Attachment E: Tuberculosis (TB) and Early Intervention Services for HIV.

By October 1, 1992, initial contacts had been made by the Division of Substance Abuse Services with the Tuberculosis Control Branch of the Alabama Department of Public Health. Planning meetings began in early November with the focus being to deliberately address preventing and treating tuberculosis for those accessing the substance abuse service system while making implementation of testing procedures of minimal disruption to programs. Immediately the issues of staff health, confidentiality regulations and consistent reporting were identified. As a result of discussions, the decision was made to train supervisors separately from clinicians and nurses in order to address administrative considerations. All staff would need training on tuberculosis and reporting procedure, etc., however, for those programs with nursing staff, retraining on placing and reading the skin test would be advisable.

Once the dilemma of both departments honoring separate sets of confidentiality regulations was identified, a detailed comparison of the laws was compiled. The end result was to find the laws basically the same with no significant areas of conflict. Both however, required individual client releases to be signed if information was to be divulged to another agency not covered under their law. Since both agencies are advocates of the client, a cooperative agreement could be developed to omit the need for releases. Another problem in this area related to the contracting arrangement with local substance abuse service providers, meaning the cooperative agreements used by the state departments would not cover substance abuse program communications to the local Health Department. To resolve this issue, a sample local interagency agreement at state level is reinforced by local agreements resulting in the elimination of individual releases when reporting the need for test results and other basic information between substance abuse and public health agencies on behalf of clients requesting services.

In order to maximize the resources of both agencies, the Division of Substance Abuse Services agreed to use the current Public Health tuberculosis reporting system and develop guidelines for all substance abuse providers in fulfilling the TB requirements. The Department of Public Health provides all supplies and equipment needed for testing except alcohol swabs and needed disposal boxes. For those programs with nursing staff, the Public Health local TB managers are available to assist on questionable test results and following up on positive results. For those programs without nursing staff, cooperative arrangements can be made for TB managers to come to the program when testing is needed by a number of clients.

Programs are also strongly encouraged to do testing of staff, although this is not a stated requirement within the Block Grant. The need for a staff testing system was obvious to the planners, along with policies and procedures of how staff TB status/issues would be accommodated.

Between February 2 and April 6, 1993, training was conducted in the four Substance Abuse Services Regions to three audiences: administrative, clinicians and nurses. The training was segmented based on the informational needs and prominent concerns of each group. The training team was made up of the SASD Chiefs of the Office of Training and the Office of Treatment Improvement along with the Director of the Public Health Department's Tuberculosis Control Branch, his assistant RN and a consultant M.D. All programs were given the option of attending any of the scheduled events, however, local Tuberculosis managers were available at meetings encompassing their district of supervision only. 56 administrators, 42 clinicians, and 54 nurses, totaling 152 participants attended the training. The training was approved for CEU credit hours for nurses, psychologists, social workers and counselors. After all training was completed a list of programs not represented at any event was compiled. The list was given to local TB managers for personal contact and technical assistance in adhering to the Block Grant testing requirements and

state guidelines. Substance abuse programs have also been encouraged to contact the Division of Substance Abuse Services or the Tuberculosis Control Branch of Public Health regarding problems that are experienced in fulfilling the grant requirements while serving clients in the most time efficient nner.

Modifications were made in Alabama's approach to TB testing based on data collected by the Department of Public. From October 1, 1993, to September 30, 1995, the Department of Public Health screened 13,556 substance abuse clients for TB. A total of two new cases of TB were discovered. The Department of Public Health recommended that due to the very low number of new cases and the very high cost of testing every admission that Alabama cut back on the requirement for testing all admissions and provide TB tests only for those clients who show symptoms.
The Alabama Substance Abuse Services Division implemented a policy beginning October 1, 1995, requiring that intake clinicians observe and refer only those clients who show symptoms.

Since the implementation of the change beginning in October 1995, most of the community programs are only testing the clients that show symptoms of TB, however, some of the programs still test all admissions. The programs that still require tests of all admissions provide testing on site using trained staff. It is the professional opinion of the staff with the Health Department and the substance abuse community treatment programs that the current approach will adequately detect TB infected clients receiving substance abuse eatment.

The Alabama Public Health Department estimates that approximately 6% of state funds expended for tuberculosis services are attributable to substance abusers. Therefore, the estimate of state TB expenditures for substance abusing citizens is calculated by multiplying the state expenditures, reported by the Public Health Department¿s Tuberculosis Branch, by 6%. In addition to these state expenditures the Alabama Department of Mental Health and Mental Retardation, Substance Abuse Services Division spends state funding to pay for screening/assessments for adolescents that include TB screening. The inclusion of these expenditures was approved (refer to attachment).

TB EXPENDITURES

Block Grant	T.B. St. Exp.	X	.06	Total State Substance Abuse Exp. + Adol. Assess	T.B. Exp.
FFY 1991	$2,470,000	x	.06	$148,200	$148,200
FFY 1992	$2,470,000	x	.06	$148,200	$148,200
FFY 1993	$2,880,000	x	.06	$172,800	$172,800
FFY 1994	$2,600,000	x	.06	$156,000	$156,000
FFY 1995	$2,600,000	x	.06	$156,000	$156,000
FFY 1996	$2,675,905	x	.06	$160,554	$160,554
FFY 1997	$2,739,148	x	.06	$164,348	$164,348
FFY 1998	$2,740,997	x	.06	$164,459	$164,459
FFY 1999	$1,400,665	x	.06	$ 84,039	+ $130,537 = $214,576
FFY 2000	$1,552,233	x	.06	$ 93,134	+ $140,560 =$233,694
FFY 2001	$1,827,974	x	.06	$109,678	+ $147,760 =$257,438
FFY 2002	$2,012,030	x	.06	$120,721	+ $147,640 =$268,361
FFY 2003	$1,767,116	x	.06	$106,026 + $132,905	238,931
FFY 2004	$2,609,454	x	.06	$156,567	+ $128,987 =$284,987
FFY 2005	$2,450,783	x	.06	$147,046 + $144,815	=$291,861
FFY 2006	$2,873,796	x	.06	$172,427	

HIV Early Intervention Efforts:

During FFY 1995 the Substance Abuse Services Division (SASD), using information

provided by the Alabama Department of Public Health, identified the mental health Catchment areas that had the highest HIV and AIDS positivity rate per 100,000 citizens. The Catchment area (M-16) including Mobile and Washington counties ranked number one. The Catchment area (M-5) including Jefferson, Blount, and St. Clair counties ranked number two. The Catchment area (M-14) including Montgomery, Elmore, Autauga, and Lowndes counties ranked number three.

During SFY 1995 contracts were entered into with the Alcoholism Recovery Service and the University of Alabama Substance Abuse Program to provide HIV Early Intervention Services in the M-5 Catchment area. A contract was entered into with the Mobile Mental Health Center to provide HIV Early Intervention Services in the M-16 Catchment area. Contracts were entered into with the Lighthouse Counseling Center and the Chemical Addictions Program to provide HIV Early Intervention Services in the M-14 Catchment area.

During SFY 1996 contracts were entered into with the East Central Mental Health Center for the M-15 Catchment area, the Cahaba Mental Health Center for the M13 Catchment area, and the Huntsville-Madison Mental Health Center for the M-3 Catchment area for the provision of HIV Early Intervention Services.

During SFY 1997 contracts were continued.

The AIDS positivity rate per 100,000 population for 1998, as reported by the Alabama Public Health Department, showed the following ranking of Mental Health Catchment Areas.

#1	M-14	Montgomery Catchment Area
#2	M-16	Mobile Catchment Area
#3	M-5	Birmingham Catchment Area
#4	M-19	Dothan Catchment Area
#5	M-21	Baldwin County Catchment Area
#6	M-2	North Central Catchment Area*
#7	M-15	East Central Catchment Area

* Catchment Area #2 is an anomaly. Limestone Prison is located in Cullman County and is used to segregate HIV/AIDS positive inmates for the entire state. The Alabama Public Health Department is working to resolve this reporting problem.

During FY's 1997-98, 1998-99, 1999-2000 and 2000-2001 the SASD contracted with four (M-14, M-16, M-5, and M-15) of the top ranking seven Catchment areas for the provision of HIV Early Intervention Services.

According to 2002 HIV/AIDS surveillance reports, the mental health catchment areas ranked as follows regarding rates of HIV/AIDS per 100,000 population.

1. M - 15
2. M - 14
3. M - 5
4. M - 19
5. M - 16
6. M - 7
7. M - 12

During FY 2002-2003 and 2004-2005 contracts with four of the top ranking catchment areas were continued (M-15, M-14, M-5 AND M-16). The contracted services include pre-test counseling, testing and post-test counseling. Alabama became a HIV designated state in 1995. At that time there were no funds, that were under the control of the Alabama Department of Mental Health or the Alabama Legislature, being spent to provide HIV services for substance abuse treatment clients. Therefore, the M.O.E. base for HIV has always been

reported as zero.

During FY 2005-2006 the SASD contracted with six of the top ranking catchment areas (M-5, M-12, M-13, M-14, M-15 and M-16) in rate of new AIDS cases per 100,000 population.

All HIV services purchased by the Substance Abuse Services Division for substance abuse treatment clients have been reimbursed with SAPT Block Grant funds.

HIV Early Intervention Expenditures

Federal Fiscal Year	State Funds	SAPT Funds	
FFY 1995	0	$ 826,677.90	
FFY 1996	0	$ 851,081.00	
FFY 1997	0	$ 974,542.45	
FFY 1998	0	$ 974,542.45	
FFY 1999	0	$1,083,342.00	
FFY 2000	0	$1,109,865.00	
FFY 2001	0	$1,149,732.95	
FFY 2002	0	$1,191,400.00	
FFY 2003	0	$1,157,343.63	
FFY 2004		0	$1,248,910.00
FFY 2005		0	$1,039,630.00
FFY 2006		0	$1,185,861.00

Alabama

Goal #7: Development of Group Homes

GOAL # 7. An agreement to continue to provide for and encourage the development of group homes for recovering substance abusers through the operation of a revolving loan fund (See 42 U.S.C. 300x-25). Effective FY 2001, the States may choose to maintain such a fund. If a State chooses to participate, reporting is required.

FY 2005 (Compliance): (participation OPTIONAL)

FY 2007 (Progress): (participation OPTIONAL)

FY 2008 (Intended Use): (participation OPTIONAL)

FY 2005 (COMPLIANCE)
FFY 2005 (Compliance):

Result: The loan has defaulted. Collection efforts have been fruitless. The project was discontinued. Refer to Attachment F.

FY 2007 (PROGRESS)
FFY 2007 (Progress):

The loan has defaulted. Collection efforts have been fruitless. The project was discontinued.

FY 2008 (INTENDED)
FFY 2008 (Intended Use):

The loan has defaulted. Collection efforts have been fruitless. The project was discontinued.

Alabama

Attachment F: Group Home Entities

Attachment F: Group Home Entities and Programs
(See 42 U.S.C. 300x-25)

If the State has chosen in Fiscal Year 2005 to participate and continue to provide for and encourage the development of group homes for recovering substance abusers through the operation of a revolving loan fund then Attachment F must be completed.

Provide a list of all entities that have received loans from the revolving fund during FY 2005 to establish group homes for recovering substance abusers. In a narrative of up to two pages, describe the following:

- the number and amount of loans made available during the applicable fiscal years;
- the amount available in the fund throughout the fiscal year;
- the source of funds used to establish and maintain the revolving fund;
- the loan requirements, application procedures, the number of loans made, the number of repayments, and any repayment problems encountered;
- the private, nonprofit entity selected to manage the fund;
- any written agreement that may exist between the State and the managing entity;
- how the State monitors fund and loan operations; and
- any changes from previous years' operations.

Attachment F: Group Home Entities

The $100,000 in FY 1989 ADMS Block Grant funds was allocated to initiate a revolving loan fund by contract with Aletheia House, Inc., a substance abuse provider in Birmingham. Any non-profit, private group could apply for a loan. To qualify for the loan, the groups must agree that:

1. The housing would be offered to four or more recovering individuals.

2. The housing would be maintained as an alcohol and drug free environment.

3. That the residents violating this rule would be expelled.

4. That the residents would pay rent which would repay the loan.

5. That the program would be operated as a self-managed democracy.

The loans would be made to non-profit, private groups, i.e., churches, civic groups, social service agencies, associations and other interested non-profit groups are eligible loan recipients.

The loans would be for no more than $4,000. This would bear an interest of 5% and must be repaid within two years. A late payment would be charged for past due payments.

A committee of alcohol/drug abuse professionals would review all loan applications. The committee would attempt to distribute loans throughout Alabama, including rural and urban areas. Loans to programs that provide housing to under served populations (e.g. pregnant women, addicts/alcoholics with physical disabilities, women and children, homeless individuals, etc.) would be given special consideration.

Aletheia House, Inc., the administrator for the revolving loan fund made a total of twenty-three loans. All of the loans were for the development of Group Homes for the recovering substance abusers.

Following is a list of the entities that received loans from the revolving fund:

1. Recovery Is Possible I — Birmingham
2. Recovery Is Possible II — Birmingham
3. CARSO — Montgomery
4. Goodwin-Herring — Birmingham
5. Hedges & Highways — Birmingham
6. Oakmont Cottage — Birmingham
7. Oakmont Center — Birmingham
8. Sunlife Services — Dothan
9. Community Service Organization — Birmingham
10. Alabama Youth Life Line — Birmingham
11. Recovery for Women — Birmingham
12. The Recovery Home — Birmingham
13. Living Sober — Birmingham
14. Mcgahee Recovery Home — Birmingham
15. The Master's House — Flat Rock
16. Miracles Happen — Birmingham
17. New Murray Temple (for women) — Anniston
18. New Murray Temple (for men) — Anniston
19. The Master¿s House #2 — Flat Rock
20. WHIP (Where Hope Is Possible) — Birmingham
21. Back On Track — Birmingham
22. One Day At A Time — Birmingham

23. Pass It On Birmingham

During FY 1991-92, Aletheia House, Inc., stopped managing the Revolving Loan Fund. A balance of $30,000 was returned to the DMH/MR. At that time twenty-three loans had been made from the Revolving Loan Fund, 11 have been turned over to a collection agency and 12 have been written off.

The SASD developed a mechanism to manage the remaining balance of the Revolving Loan Fund. The following loans have been made since DMH/MR assumed the management of the fund.

1. September 28, 1994, a loan was made to Oxford House Perryhill Road, Montgomery, the loan of $4,000 was repaid in full.

2. September 13, 1994, a loan was made to Oxford House Locust, Montgomery, The loan of $3,000 was defaulted after nine payments, leaving an uncollected balance due of $1,793.48.

3. June 20, 1996, a loan was made to the Quad Cities Oxford, Sheffield, the loan of $4,000 is being repaid. The last payment was received May 27, 1998, in the amount of $354.26. The current remaining balance is $170.42.

4. May 14, 1997, a loan was made to Grandview Oxford House, Sheffield, the loan of $4,000 was made, and no payments have been made thus far. Collection efforts have been fruitless.

5. June 22, 2001, a loan was made to We Are Women in Recovery. The loan of $4,000 is being repaid at a rate of $177.28 per month. The first payment was received on 8/17/2001. The current balance is $3,540.78.

The loan has defaulted. Collection efforts have been fruitless. The project was discontinued.

Alabama

Goal #8: Tobacco Products

GOAL # 8. An agreement to continue to have in effect a State law that makes it unlawful for any manufacturer, retailer, or distributor of tobacco products to sell or distribute any such product to any individual under the age of 18; and, to enforce such laws in a manner that can reasonably be expected to reduce the extent to which tobacco products are available to individuals under age 18 (See 42 U.S.C. 300x-26 45 C.F.R. 96.130 and 45 C.F.R.96.122(d)).

- Is the State's FY 2008 Annual Synar Report included with the FY 2008 uniform application?
  Yes No
- If No, please indicate when the State plans to submit the report:
  mm/dd/2007

Note: The statutory due date is December 31, 2007.

The State's FY 2008 Annual Synar Report is not included with the FY 2008 uniform application. The State plans to submit the FFY 2008 ASR at the time of þÿ t h e A S R s O M B a p p r o v a l .

GOAL #8. Alabama has already established a State Law, which makes it unlawful for any manufacturer, retailer, or distributor of tobacco products to sell or distribute any such product to any individual under the age of 19.

Alabama has developed a methodology for the enforcement of the law that can reasonably be expected to reduce the extent to which tobacco products are available to individuals under the age 19.

Objective: Reduce the availability of tobacco and tobacco products to minors in Alabama.

FFY 2005 (Compliance):

Result: Accomplished. Refer to Appendix B, for a complete description of the activities.

Activity: The compliance, enforcement and reporting plan will be implemented.

Current Status: Accomplished.

Activity: The SASD will contract for the provision of the compliance and reporting requirements.

Current Status: Accomplished.

Activity: The appropriate reports will be submitted to the Center for Substance Abuse Prevention.

Current Status: The report is being compiled for inclusion with the 2004 Block Grant Application. Accomplished.

FFY 2007 (Progress):

Result: Accomplished. Refer to Appendix B, for a complete description of the activities.

Activity: The compliance, enforcement and reporting plan will be implemented.

Current Status: Accomplished.

Activity: The SASD will contract for the provision of the compliance and reporting requirements.

Current Status: Accomplished.

Activity: The appropriate reports will be submitted to the Center for Substance Abuse Prevention.

Current Status: The report is being compiled for inclusion with the 2007 Block Grant Application.

FFY 2008 (Intended Use):

Activity: The compliance, enforcement and reporting plan will be implemented.

Activity: The SASD will contract for the provision of the compliance and reporting requirements.

Activity: The appropriate reports will be submitted to the Center for

Substance Abuse Prevention.

Alabama

Goal #9: Pregnant Women Preferences

GOAL # 9. An agreement to ensure that each pregnant woman be given preference in admission to treatment facilities; and, when the facility has insufficient capacity, to ensure that the pregnant woman be referred to the State, which will refer the woman to a facility that does have capacity to admit the woman, or if no such facility has the capacity to admit the woman, will make available interim services within 48 hours, including a referral for prenatal care (See 42 U.S.C. 300x-27 and 45 C.F.R. 96.131).

FY 2005 (Compliance):

FY 2007 (Progress):

FY 2008 (Intended Use):

FY 2005 (COMPLIANCE)
GOAL #9. The Substance Abuse Services Division, through prioritization and waiting list maintenance, assures that each pregnant woman is given preference in admission to treatment facilities and, when a facility has insufficient capacity, assures that the pregnant woman is referred to the State, which will refer the woman to a facility that does have capacity to admit the woman, or if no such facility has the capacity to admit the woman, will provide interim services, including a referral for prenatal care.

Objective: Pregnant women are given preference in admission to substance abuse treatment services in Alabama and interim services are provided when facilities do not have the capacity to admit.

FFY 2005 (Compliance):

Result: Accomplished. Pregnant women were given priority admission for treatment and placements were managed by the Treatment Access Project (T.A.P.) according to block grant requirements. Refer to Attachment G for a complete description of the activities.

FY 2007 (PROGRESS)
FFY 2007 (Progress):

Activity: All contracts will contain a prioritized listing of clients for admission. Pregnant women will be the first priority.

Current Status: Accomplished.

Activity: The Treatment Access Project (T.A.P.), which is driven by priorities for admission set by the block grant requirements, will be operational. The T.A.P. is fully explained in Attachment G of this application.

Current Status: Accomplished.

Activity: System capacity will be managed through T.A.P.

Current Status: Accomplished.

Activity: Waiting lists will be managed through T.A.P.

Current Status: Accomplished.

Activity: Training and technical assistance will be made available regarding T.A.P.

Current Status: Accomplished.

FY 2008 (INTENDED)
FFY 2008 (Intended Use):

Activity: All contracts will contain a prioritized listing of clients for admission. Pregnant women will be the first priority.

Activity: The Treatment Access Project (T.A.P.), which is driven by priorities for admission set by the block grant requirements, will be operational. The T.A.P. is fully explained in Attachment H of this application.

Activity: System capacity will be managed through T.A.P.

Activity: Waiting lists will be managed through T.A.P.

Activity: Training and technical assistance will be made available regarding T.A.P.

Alabama

Attachment G: Capacity Management

Attachment G: Capacity Management and Waiting List Systems
(See 45 C.F.R. 96.122(f)(3)(vi))

For the fiscal year two years prior (FY 2006) to the fiscal year for which the State is applying for funds:

In up to five pages, provide a description of the State's procedures and activities undertaken, and the total amount of funds expended (or obligated if expenditure data is not available), to comply with the requirement to develop capacity management and waiting list systems for intravenous drug users and pregnant women (See 45 C.F.R. 96.126(c) and 45 C.F.R. 96.131(c), respectively). This report should include information regarding the utilization of these systems. Examples of procedures may include, but not be limited to:

- development of procedures (and any subsequent amendments) to reasonably implement a capacity management and waiting list system;
- the role of the Single State Authority (SSA) for substance abuse prevention and treatment;
- the role of intermediaries (county or regional entity), if applicable, and substance abuse treatment providers; and
- the use of technology, e.g., toll-free telephone numbers, automated reporting systems, etc.

Examples of activities may include, but not be limited to:

- how interim services are made available to individuals awaiting admission to treatment;
- the mechanism(s) utilized by programs for maintaining contact with individuals awaiting admission to treatment; and
- technical assistance.

Attachment G: Capacity Management and Waiting List Systems.

History:

In the summer of 1992 more than 800 citizens were included on waiting lists for residential treatment for substance abuse in Alabama. At that time action was taken by the SASD to improve the situation and work toward equal access to treatment for appropriate substance abuse clients. Thus, the Treatment Access Project (TAP) was launched on October 1, 1992.
The capacity management system was developed at no extra cost.
The SASD training team staff traveled around the state informing providers, soliciting their input, and providing technical assistance and training in the new automated admissions system which included the TAP. A cross section of volunteers was recruited from the substance abuse provider network and the Alabama Council of Community Mental Health Centers. The TAP volunteers work group began its work in January 1992.
Accomplishments:

Over a period of ten months, the TAP workgroup worked diligently, developing standardized waiting list protocols, assessment procedures, adult crisis residential referral criteria, and uniform statewide release of confidential information. A large portion of the TAP work group¿s efforts was focused on the development of a model for internal prioritization, waiting list and capacity management systems as required by the Federal Block Grant. TAP¿s first statewide training seminar was conducted in September 1993. The seventy-five participants included program directors and coordinators, assessment specialists, and waiting list specialists, representing most of the state's contracted assessment centers (IOP's) and residential treatment providers. A TAP Training and Procedures Manual was developed and is available to providers upon request. TAP maintains a statewide directory of service providers that is also available upon request.

In 1994 the TAP work group developed the standardized assessment package required by treatment centers prior to placing a client on the waiting list. In 1995 the work group undertook the laborious task of revising the standardized psychosocial assessment instrument including elements from the nationally endorsed Addiction Severity Index (ASI) instrument. The revised instrument was implemented October 1, 1995.

Current Operations:
The Office of Research, Evaluation and Information is assigned to manage Alabama's TAP which includes capacity management and management of waiting list systems. In 1997 the TAP process was modified. On a weekly basis, a statewide window is obtained from all of the state¿s contracted residential substance abuse treatment providers. TAP maintains a current record of the number of clients on waiting lists by priority codes and reports this information weekly to the Director of the SASD, the Commissioner of the DMH/MR. This report is then made available via the web at http://www.mh.alabama.gov at the SASD link. This information is used by referral agencies for speedier placement of priority population clients. A monthly survey of provider waiting lists is conducted to ascertain an accurate count of unduplicated clients waiting for treatment. TAP's Capacity Management Program requires providers receiving Block Grant Funds, who provide services to injectable drug users, to report to the state when they reach 90 percent of capacity. TAP's Waiting List Management Program provides systematic reporting of treatment demand to the state. TAP requires each provider to establish and maintain an internal Waiting List/Capacity management System, and to give pregnant women, women with dependent children and injectable drug users priority for residential treatment services. Providers must offer interim services to top priority clients while they are waiting for residential treatment. The Block Grant requirements are built into the TAP's programs.

Alabama

Goal #10: Process for Referring

GOAL # 10. An agreement to improve the process in the State for referring individuals to the treatment modality that is most appropriate for the individual (See 42 U.S.C. 300x-28(a) and 45 C.F.R. 96.132(a)).

FY 2005 (Compliance):

FY 2007 (Progress):

FY 2008 (Intended Use):

FY 2005 (COMPLIANCE)
FFY 2005 (Compliance):

Result: Accomplished. A standardized psycho-social assessment process has been developed, and is in a continuous state of refinement, designed to improve the process for referring individuals to the treatment modality that is most appropriate for the individual.

FY 2007 (PROGRESS)
FFY 2007 (Progress):

Activity: Specific referral criteria will be developed for each service available, i.e. crisis residential, residential rehabilitation, intensive outpatient, methadone, etc.

Current Status: Accomplished.

Activity: The referral criteria will be incorporated as a part of the Treatment Access Project (T.A.P.).

Current Status: Accomplished.

FY 2008 (INTENDED)
FFY 2008 (Intended Use):

Activity: Specific referral criteria will be developed for each service available, i.e. crisis residential, residential rehabilitation, intensive outpatient, methadone, etc.

Activity: The referral criteria will be incorporated as a part of the Treatment Access Project (T.A.P.).

Alabama

Goal #11: Continuing Education

GOAL # 11. An agreement to provide continuing education for the employees of facilities which provide prevention activities or treatment services (or both as the case may be) (See 42 U.S.C. 300x-28(b) and 45 C.F.R. 96.132(b)).

FY 2005 (Compliance):

FY 2007 (Progress):

FY 2008 (Intended Use):

FY 2005 (COMPLIANCE)
GOAL #11. The Substance Abuse Services Division will provide continuing education and continuing education units for the employees of facilities which provide prevention activities and treatment services.
SASD will partner with the Alabama Alcohol and Drug Abuse Association to provider continuing education units for all trainings. In order to address the workforce needs SASD has a position on the following boards; Alabama Alcohol and Drug Abuse Association (certifies treatment and prevention professional), Alabama School for Alcohol and Other Drug Studies, Southeastern School of Alcohol and Other Drug Studies, Appalachian School of Alcohol and Other Drug Studies and Southern Coast ATTC. These board positions allow SASD to participate in the planning and development of conferences to address the workforce needs of the treatment and prevention professionals across the state. The goal of SASD is to offer prevention and treatment courses at every conference.

Objective: Employees of organizations providing substance abuse treatment and prevention services have access to continuing education and continue education units. SASD has partnered with the Alabama Alcohol and Drug Abuse Association to provide continuing education units for all trainings. SASD will continue to participate on the above mentioned boards in order to be a part of the planning and development of conferences through out the state for treatment and prevention professionals.

FFY 2005 (Compliance): Oct 2004 - Sept 05

Results: Accomplished: The Substance Abuse Services Division conducted training for substance abuse program staff in various locations throughout the State. Continuing education units were offered for all the training through the Alabama Alcohol and Drug Abuse Association. There were 24 training events reaching 1475 participants throughout the state of Alabama .They are as follows: 1.) 6-CO-OCCURRING trainings offered in partnership with the Southern Coast ATTC. One of the seven training was a Training of Trainers- Co-Occurring Disorders. The purpose was to provide with state wide trainers to help aide þÿ p r o v i d e r s t o b e c o m e c o - o c c u r r i n g c o m p e t e approach. 2.) 3-CRISIS INTERVENTION trainings were held in three locations around the state to help all first responders (police, sheriff, emergency room worker, jailers, etc.) understand the signs, symptoms, and how to respond to a person in a crisis with a substance abuse and/or mental illness problem. 3.) 3-CASE MANAGEMENT trainings were held to train new substance abuse case þÿ m a n g e r s . 4 .) 1 2 - C r i s i s C o u n s e l i n g T h e Illness Division work together to obtain a FEMA grant for the Hurricane Ivan. Alabama had eleven counties declared a disaster

Through a well established partnership with the above mentioned boards SASD has been able to provide continuing education and continued education units as outlined below.

Activity: The Substance Abuse Services Division assisted in the planning and development of courses, and provided scholarships to the annual Alabama School of Alcohol and Other Drug Studies was held in Tuscaloosa AL in March. Continuing education units were offered.

Current Status: Accomplished. Total attendees: 573

Alabama School of Alcohol and Other Drug Studies: Treatment courses offered: 1.) CONFIDENTIALITY AND PRIVACY. - This workshop provided the fundamental of the Federal confidentiality and privacy laws; discussed the integration of these Federal laws and their general relationship to State law; explored the process of decision making in handling a request, use of disclosure of individually identifiable health information; and explored methods of þÿ c o l l a b o r a t i o n w i t h i n t h e p r i v a c y a n d c o n

FY 2005 (COMPLIANCE)
þÿ S T D S F O R A D D I C T I O N S A N D M E N T A L H E A L T H W
overview of current developments in STD/HIV diagnosis and management to the lay (non-STD) professional involved in the counseling and education of individuals living with a dual diagnosis, i.e., alcohol/drug addiction and a sexually transmitted diseases/infection including HIV/AIDS. 3.) SPIRITUALITY & THE 12
þÿ S T E P S T h i s c o u r s e e x p l o r e d t h e s p i r i t u
þÿ 4 .) W O R K I N G W I T H R E S I S T A N T C L I E N T S T h
issues that surface in working with resistant substance abusing or chemically dependent clients. Participates gained an improved understanding of the pathology of addiction, the psychological dynamics of addiction, and effective interventions to overcome the resistance inherent in working with this
þÿ p o p u l a t i o n . 5 .) E t c h Y o u r S k e t c h T h i s c
awareness. þÿ U s i n g a s e r i e s o f t h o u g h t g r a m s a n
journaling, this course refreshed their spirits toward encouraging the human
þÿ s i d e o f l i f e a n d w o r k . 6 .) R E L A T I O N S H I P S
RELATIONSHIPS - This workshop explored the dynamics of unhealthy relationship involvement that typically occurs in clients afflicted with or affected by addiction, and also examined the healthy counterparts which can lead to contented, intimate, and mutually beneficial relationships. 7.) COPING,
þÿ C O M P A S S I O N A T E , O R C O - D E P E N D E N T ? T h r o u g h
discussion groups and lecture, participants had the opportunity to examine the journey of recovery for family members and friends of substance abusers. 8.)
þÿ H i p - H o p S o b r i e t y T h i s w o r k s h o p e x a m i n e
þÿ H i p - H o p c u l t u r e a n d i m p l i c a t i o n s f o r e
and chemically dependent clients from this environment. 9.) MOTIVATIONAL INTERVIEWING FOR INDIVIDUAL AND GROUP SUBSTANCE ABUSE TREATMENT DESCRIPTION: This course taught the key principles of Motivational Interviewing. 10.) SUICIDE PREVENTION AND INTERVENTION: - This course taught participants about the current resources and information related to suicide prevention and developed techniques for suicidal risk assessment and helped identify stages from ideations to involuntary commitment. 11.) CROSSING THE BORDER CLINICAL & CULTURAL ISSUES PUTTING PREPAREDNESS INTO ACTION WITH HISPANIC CLIENTS- This course to assisted participants in improving their service delivery efforts with limited English proficiency (L.E.P.) Hispanic population. The course also addressed the cultural and clinical concerns experienced in providing quality treatment and case management services across the language barrier. 12.) UNDERSTANDING DOMESTIC VIOLENCE AND SUBSTANCE ABUSE - This course educated professionals in the target populations to understand the nature and extent of domestic violence and the increase in complexity of dealing with domestic violence and substance abuse when both problems co-exist. It focused on understanding the dynamics of domestic violence, including the cycle of violence and escalating nature of such violence. 13.) CONDUCTING SERIOUS INCIDENT INVESTIGATIONS - This was an introductory course designed to provide information and techniques for conducting incident investigations in an impartial and objective manner, to obtain accurate information needed to
þÿ e x p l a i n o r d e s c r i b e a n d e v e n t . 1 4 .) I N T R
Through experiential role play, participants worked in teams and were interactive with the instructors in order to experience counseling responsibilities regarding intake, psycho-socio history assessment, treatment planning, group work, family interaction, referrals (co-occurring disorders), discharge planning, and documentation.
þÿ 1 5 .) D R U G S O N T H E C U T T I N G E D G E T h i s c
substance abuse, their effects, typical behaviors, associated paraphernalia, medical complications, and constraints faced by professionals. 16.) COGNITIVE
þÿ I N T E R V E N T I O N W I T H S U B S T A N C E A B U S I N G O F F E
teach attendees an effective behavior modification method for use in treating substance-abusing offenders. 17.) ADOLESCENT THERAPY: THINKING OUTSIDE THE BOX -This workshop focused on the components vital to having a successful adolescent treatment program. A number of important issues concerning the development and maintenance of adolescent treatment programs were discussed including: working with adolescents and their families, working with the

FY 2005 (COMPLIANCE)
juvenile justice community, networking with community resources, and utilizing adventure-based counseling with adolescents and their families. 18.) THE USE OF PSYCHODRAMA (ROLE PLAY) IN SUBSTANCE ABUSE GROUP THERAPY - This was an experiential workshop in which participants had spontaneous dialogues on substance abuse related issues, based on prewritten characterizations and plots.. 19.) ADDING TOOLS TO YOUR TOOL BOX: SUCCESSFUL TREATMENT OF THE þÿ C O - O C C U R R I N G C L I E N T S This workshop discussed new research findings as it relates to addictive disorders, recovery, and relapse. 20.) HEALING THE ANGRY HEART: Examined how the DSM-IV described Affective and þÿ A n x i e t y D i s o r d e r s . 2 1 .) E T H I C A L R E Q U I R E M E N T S þÿ w o r k s h o p r e v i e w e d b a s i c e t h i c s r e q u i r e and privacy laws; discussed the challenges that face institutions in developing ethics standards under these laws; clarifies the role that boards of trustees, senior staff and front-line professionals can play in achieving compliance with ethics requirements; and compares the stringency of privacy standards in various professional codes of ethics against those in privacy statutes. 22.) þÿ R E - E N G A G I N G I T ' S W O R T H I T This workshop focused on the art of mainstreaming the addict into a useful, productive role in society, utilizing a blend of timing, professional skills, techniques, and applied clinical practices. 23.) þÿ T H E S E N T E N C I N G C O M M I S S I O N T h i s t r a i n i n creation, goals and achievements of the Sentencing Commission, with a brief historical description of the crisis leading up to the Commission's creation. þÿ 2 4 .) T H E M E T H A M P H E T A M I N E C R I S I S T h i s c addiction and its unique qualities that have brought it to epidemic levels in rural America and now showing up in urban areas. . 25.) CARING FOR SEXUAL TRAUMA/ABUSE AND DATE RAPE- This session examined the feelings frequently felt by victims; it also examined the phenomena of date rape; addressed the relationship between drugs and sexual assault, and examined how care givers can help victims of sexual trauma and assault. 26.) SEXUAL OFFENDER COMMUNITY þÿ N O T I F I C A T I O N A C T A n o v e r v i e w o f t h e C o þÿ t o l o c a l l a w e n f o r c e m e n t . 2 7 .) B A B Y N E E D S DREAM; GAMBLING - This course examined gambling from a number of different angles. Participants become familiar with the warning signs and how gambling could mask other addictions and vice - versa.

Prevention courses offered: þÿ 1 .) I T S A T E A M S T O B U I L D A N D STRENGTHEN COALITIONS- Participants learn the importance of power of community anti-drug coalitions and how to form and sustain effective coalitions. 2.) þÿ H I V / A I D S / E t h i c s T h i s w o r k s h o p d e a l t w i providing services to HIV and high risk consumers. 3.) SPECIAL POPULATIONS IN THERAPY: þÿ P E R S P E C T I V E I N P R E V E N T I O N A N D C O M M U N provided an informational overview on how to provide comprehensive therapy to special populations of substance abusers for a prevention and community outreach approach. The approaches specifically targeted uniquely identify populations such as homeless persons, incarcerated/ex-offenders, HIV infected person, gay/lesbian/bisexual/transgender person. 4.) BEST BANG FOR THE BUCK: þÿ S E L E C T I N G A P P R O P R I A T E S C I E N C E - B A S E D P R O G definition, levels and rational behind science-based programming and was exposed to examples of science-based and non-science-based programming. 5.) 7 þÿ H A B I T O F H I G H L Y E F F E C T I V E L Y P E O P L E P a r managing their time and their lives and learned to utilize the tools of conflict resolution.

Activity: The Substance Abuse Services Division assisted in the planning and development of courses, and provided scholarships to the annual Southeastern School of Alcohol and Drug Studies, which is held in Athens, Georgia in August. 2005. Continuing education units were offered.

Southeastern School of Alcohol and Other Drug Studies Treatment courses offered: 1.) ANGER MANAGEMENT - This course addressed anger management theory þÿ a n d e f f e c t i v e i n t e r v e n t i o n s . 2 .) A D V E N T U

experiential course that taught participants to use games and initiatives and other fun activities to enhance groups.3.) CHURCH AND FAITH BASED INITIATIVES - Through this course participant were able to understand what the faith based initiatives is and the role of the community 4.) CLINICAL SUPERVISOR - This course focused on the teaching and mentoring aspects of clinical supervision in þÿ a d d i c t i o n t r e a t m e n t s e t t i n g s . 5 .) E F F E C T I focused on exploring strategies for age and gender appropriate programming. 6.) HEALING THE HEALER - This course taught participants stress management techniques that can be use personally and prefoessional.7.) MANAGING FOR þÿ S U C C E S S T h r o u g h t h i s c o u r s e p a r t i c i p a n elements of conflict þÿ 8 .) M O T I V A T I O N A L I N T E R V I E W I N theoretical knowledge with practical skill used to empower clients to change. 9.) NEW INTERVENTION TECHNIQUES - Participants were able to do interventions þÿ a n d a s s e s s m e n t s i n t h i s w o r k s h o p . 1 0 .) T R explained the short and long term effects of methamphetamine use on the brain. 11.) UNDERSTANDING CRIMINAL THINKING AND ADDICTIVE THINKING- This course examined both the criminal and addictive thinking patterns. 12.) CHEMICALLY DEPENDENT JUVENILE OFFENDER - This was a skill building workshop that enabled participants to work more effectively with juveniles 3.) CORE ADDICTION TREATMENT SKILLS- This course proved opportunities for professionals to receive up to date education and training in field addiction treatment services þÿ d e l i v e r y . 1 4 .) G R O U P T H E R A P Y T h i s c o u r þÿ o c c u r i n t r e a t m e n t g r o u p s . 1 5 .) H E L P I N G þÿ f o u r b a s i c e m p o w e r m e n t a b i l i t i e s n e e d e d þÿ t h e i r l i v e s . 1 6 .) I G A V E A T T H E O F F I C E can assist professional in forming and maintaining healthier boundaries, revitalizing their relationships and creating a send of well-being. 17.) SUBSTANCE ABUSE TREATMENT FOR PERSON WITH CO-OCCURRING DISORDER -This course examined strategies for treating person with co-occurring disorders. 18.) ADOLESCENT GIRLS IN THE JUVENILE JUSTICE SYSTEM WITH CO-OCCURRING þÿ D I S O R D E R S T h i s w a s a s k i l l b u i l d i n g c o more effectively in the juvenile justice system.19.) GANGS AND SUBSTANCE ABUSE þÿ - T h i s c o u r s e h e l p e d p a r t i c i p a n t s t o d e f i þÿ R E C O V E R Y T h i s w a s a h i g h l y e x p e r i e n t i a to help their clients deal with issues that many men face in recovery. 21.) þÿ O V E R C O M I N G C O M P A S S I O N F A T I G U E T h i s c o u þÿ t a k e c a r e o f t h e c a r e g i v e r . 2 2 .) R E L A P S E taught initial relapse prevention skills. 23.) LAUGHTER: þÿ T H E 1 3 T H S T course helped participants take a lighter look at their lives and their attitudes surroundings these important elements of recovery.

Prevention courses offered: An addiction to the school was a specialized track for prevention professionals called Prevention Institute Emerging Issues. The Institute is a cooperative effort between the Southeast Center for Advancement of prevention Technology and the Southeastern School. The prevention Institute designed a week long course for prevention professionals. Course taught during the week: þÿ 1 .) E X P L O R I N G P R E V E N T I O N E T H I C S A presented and participants were intensely involved in working through relevant þÿ c a s e s t u d i e s u s i n g t h e m o d e l . 2 .) HOWHTA N G E þÿ A S S E S S A N D S T R E N G T H E N P R E V E N T I O N N E T W O R K þÿ p a r t i c i p a n t s i n a s s e s s i n g t h e i r c o m m u n i t helped them develop a plan to improve priority characteristics. 3.) þÿ M U L T I C U L T U R A L I S S U E S I N P R E V E N T I O N T h i issues and the importance of becoming multiculturally competent. 4.) þÿ E N V I R O N M E N T A L S T R A T E G I E S T h i s t r a i n i n g to illustrate the planning process to develop effective prevention efforts. 5.) PROGRAM FIDELITY AND ADAPTATION - This training stressed the importance of adapting effective programs and strategies to local needs.

Current Status: Accomplished. Total attendees: 361

Activity: The Substance Abuse Services Division assisted in the planning and

FY 2005 (COMPLIANCE)
development of courses, and provided scholarships to the annual Alabama Alcohol and Drug Abuse Prevention Conference held in Birmingham AL in Aug. Continuing education units were offered.

Prevention courses offered:
þÿ 1 .) A D D I N G S P I C E T O E V I D E N C E D B A S E D P R O G
experiential learning. 2.) THE PSYCHOLOGY OF ADDICTION -This course explored
the basic design of the human brain. þÿ 3 .) B A B Y T H I N K I T O V E
educated participants about teenage pregnancy prevention education. 4.)
þÿ H I V / A I D S F O R T H E P R E V E N T I O N S P E C I A L I S T
þÿ H I V / A I D S . 5 .) S T R E S S M A N A G E M E N T T h i s c
to problems and consequences of uncontrolled stress. 6.) FAMILY SYSTEMS
þÿ D Y N A M I C S T h i s c o u r s e e x a m i n e d t h e r o l e
þÿ M E T H A M P H E T A M I N E T h i s c o u r s e d i s c u s s e d
þÿ 8 .) P R E V E N T I O N C E R T I F I C A T I O N W R I T T E N R E V
participants prepare for the written exam. 9.) ETHICS FOR THE PREVENTION
þÿ S P E C I A L I S T T h i s c o u r s e h e l p e d p a r t i c i p
possible solution. 10.) THE DILEMMA OF DEALING WITH CO-OCCURRING DISORDERS IN
þÿ P R E V E N T I O N T h i s c o u r s e h e i g h t e n e d a w a r
þÿ c o - o c c u r r i n g d i s o r d e r s . 1 1 .) M A N A G I N G D I
introduced a variety of techniques to handling difficult audiences. 12.)
þÿ I N T R O D U C T I O N T O 1 2 S T E P R E C O V E R Y P R O G R A M
the 12 step modalities and of support group meetings. 13.) BASICS OF THE
þÿ J U V E N I L E J U S T I C E S Y S T E M T h i s c o u r s e d i
þÿ a b u s e a m o n g y o u t h . 1 4 .) N A T I O N A L T R E N D I
the latest innovative approaches to the implementation of prevention programs.
þÿ 1 5 .) I S S U E S I N A D O L E S C E N T S T h i s c o u r s e
developmental strategies related to adolescents.

Current Status: Accomplished. Total participants 65

FY 2007 (PROGRESS)
Activity: The Substance Abuse Services Division has provided continuing education and continuing education units for the employees of facilities which provide prevention activities and treatment services.
SASD partnered with the Alabama Alcohol and Drug Abuse Association to provider continuing education units for all trainings. In order to address the workforce needs SASD has positions on the following boards; Alabama Alcohol and Drug Abuse Association (certifies treatment and prevention professional), Alabama School for Alcohol and Other Drug Studies, Southeastern School of Alcohol and Other Drug Studies, Appalachian School of Alcohol and Other Drug Studies and Southern Coast ATTC. These board positions have allowed SASD to participate in the planning and development of conferences that have addressed the workforce needs of the treatment and prevention professionals across the state. The goal of SASD was to offer prevention and treatment courses at every conference.

Current Status: Accomplished. SASD, Office of Certification and Training conducted training for substance abuse program staff in various locations throughout the State. There were 24 training events reaching 2205 participants throughout the state of Alabama .They are as follows: 1.) 3- HIPPA with an AOD Twist trainings offered in partnership with the University of Alabama at Birmingham AIDS Education Training Center, Alabama Alcohol and Drug Abuse Association (AADAA), Alabama Mental Health Counselors Association and SAMHSA 2.) Alabama School of Alcohol and Other Drug Studies 3.) 2- AADAA - Fall Conference and Prevention Conference 4.) Southeastern School of Alcohol and Other Drug Studies 5.) 3- Substance Abuse Case Management 6.) Training for SASD Site Reviewers 7.) 4- FEMA Crisis Counseling Training 8.) 2 - Substance Abuse Advocacy 9.) Deaf Interpreters Training 10.) Identifying Drugged People 11.) Client Centered Treatment Planning 12.) 2 - Documentation Training A1 13.) Appalachian School of Alcohol and Other Drugs Studies þÿ 1 4 .) A l a b a m a M e t h a d o n e T r e a t m e n t

The Substance Abuse service Division has provided on site technical assistance to substance abuse providers regarding the Matrix Model, Evidence Based Practices, and Co-Occurring,

The Office of Certification and Training conducted a treatment and prevention workforce survey in conjunction with SCATTC. A 3 SASD Workforce Committee has been formed with members from the certifying boards, 2 and 4 years colleges, SCATTC, and treatment and prevention providers. They have begun to work on a workforce plan for the state.

Activity: The Substance Abuse Services Division assisted in the planning and development of courses, and provided scholarships to the annual Alabama School of Alcohol and Other Drug Studies was held in Tuscaloosa AL in March. Continuing education units were offered.

Treatment courses offered: 1.) THE METHAMPETAMINE CRISIS - This course helped participants understand methamphetamine addiction and its unique qualities that brought it to epidemic levels in rural America and why it is now showing up in urban areas. 2.) THE JUVENILE SEXUAL OFFENDER: WHAT THE DATA ARE TELLING US, þÿ W H A T W E R E D O I N G A B O U T I T , A N D W H A T W E D provided an overview of juvenile sexual offending and an introduction to the treatment and case management of the juvenile sexual offender. 3.) HEALING AN ANGRY HEART: þÿ T R E A T I N G A N G E R A N D A G G R E S S I O N I N training event described treatment planning based on the variables of environment, medication and empirically proven psychotherapeutic approach. 4.) þÿ B U L L I E S F R O M T H E P L A Y G R O U N D T O T H E B O A R D þÿ b u l l y i n g i n þÿ 5 .) w A D V O C A C Y . W H A T S T H E discussed ways to reduce the stigma associated with substance abuse and substance use, how to initiate funding sources, and how to effectively communicate with your legislators, community leaders and the media. 6.) WILL þÿ Y O U R R E C O R D S D O C U M E N T A T I O N S T A N D U P I N

FY 2007 (PROGRESS)
importance of accurate and timely health record documentation. 7.)
þÿ P O S T T R A U M A T I C S T R E S S D I S O R D E R (P T S D) A N D
discussed key biological, social, and clinical issues related to the case
management and treatment of individuals diagnosed with PTSD and substance use
disorders. 8.) CONFIDENTIALITY AND PRIVACY PROTECTIONS UNDER FEDERAL STATUTES
þÿ F O R P A R T I C I P A N T S I N T H E C R I M I N A L J U S T I C E
that covered Federal confidentiality and privacy regulations affecting criminal
justice programs that refer substance abuse patients. 9.) ETHICS AND HIV/AIDS
þÿ F O R T H E P R O F E S S I O N A L A l l o w e d p r o f e s s i o
codes of ethics, how to make ethical decisions, how to avoid malpractice suits
and information to help the recovering professional maintain well established
boundaries. þÿ 1 0 .) S P I R I T U A L I T Y A N D T H E 1 2 S T E P S
explore the spiritual aspects of the 12-Steps of recovery. 11.) MARIJUANA-THE
þÿ M E T H A D D I C T S C A L M A T I V E A c o m p r e h e n s i v
pharmacology of both methamphetamine and marijuana. 12.) WHO ETCHED ON YOUR
þÿ S K E T C H U s i n g a s e r i e s o f t h o u g h t - g r a m s
this course refreshed our spirits towards encouraging the human side of life
and work. 13.) ATTRIBUTES OF EFFECTIVE COUNSELORS -This training sought to
assist in clarifying the attributes to improve the counselors functioning in a
therapeutic setting. It discussed the skills and insights necessary for
effective counseling in a multi-cultural setting. 14.) EFFECTIVE APPROACHES TO
GANG, YOUTH VIOLENCE & DRUG DEALING: Part One: Developing a Plan that has a
þÿ C h a n c e t o S u c c e e d P a r t 1 w a s d e s i g n e d
gang involvement and the gang sub-culture; how to impact youth drug dealing;
and research based strategies for addressing these issues. 15.) MANAGING
þÿ S T R E S S I N T H E W O R K P L A C E T h i s s e s s i o n a d
stress, some causes of stress in the workplace and ways to reduce or manage
stress. þÿ 1 6 .) I N T E N S I V E S K I L L T R A I N I N G I N M O T
objective of this course was to help participants understand the underlying
concepts of Motivational Interviewing. 17.) TRANSFORMING TREATMENT APPROACHES
þÿ F O R P R E G N A N T , P O S T - P A R T U M A N D P A R E N T I N G
þÿ w o r k s h o p f o c u s e d o n t h e c u r r e n t s t a t e o f
known on the basis of evidence-based treatment and clinical experience, and
suggested effective practices for substance abuse staff working with female
clients with children. 18.) DRUG TESTING-HOW TO TURN YOUR DRUG TESTING INTO A
þÿ F U N D I N G S O U R C E F O R Y O U R P R O G R A M T h i s c
establishing a drug testing program; how to promote accurate and reliable drug
testing and establish a method for programs to turn their drug testing into a
profit center for their organization. 19.) UNDERSTANDING DOMESTIC VIOLENCE AND
þÿ S U B S T A N C E A B U S E T h i s c o u r s e w a s d e s i g n
nature and extent of domestic violence and the increase in complexity of
dealing with domestic violence and substance abuse. 20.) BASIC GROUP
þÿ C O U N S E L I N G S K I L L S F O R T H E S U B S T A N C E A B U S
combination of didactic and experiential learning. We focused on basic group
skills such as the development of group and the appropriate intervention in
different stages of growth. þÿ 2 1 .) T H E T R O U B L E D E M P L O Y E
on the many ways employees can be troubled in their own mind and spirit and/or
body. þÿ 2 2 .) E V O L U T I O N O F M E D I C A T I O N A S S I S T E
History and systems of medication for treatment of opiate dependency was
reviewed with emphasis on the use of opiate replacement medications such as
methadone, LAAM, and Buprenorphine. þÿ 2 3 .) T H E M E T H A D D I C T S
þÿ N E U R O B I O L O G Y A N D P H A R M A C O L O G Y O F M E T H A M P
understanding of the short and long term effects of methamphetamine. 24.)
þÿ F A M I L Y T R E A T M E N T O F A D D I C T I V E D I S O R D E R S
variables that have been isolated as instrumental in the early development of
chemical dependency. 25.) EFFECTIVE APPROACHES TO GANG, YOUTH VIOLENCE & DRUG
DEALING: Part Two: þÿ E x e c u t i n g a S u c c e s s f u l P l a n t h a
learned to implement outcome oriented plans. They also learned a four-step
evaluation process for evaluating the effectiveness of their community plans.
26.) þÿ P R E A N D P O S T R E L E A S E D Y N A M I C S O F T H E
training was designed to aid counselors in developing an understanding of the

multiple dynamics that may occur while working with offenders in a residential þÿ a n d o u t - p a t i e n t s e t t i n g . 2 7 .) P R E P A R I N G
þÿ E X A M T h i s c o u r s e i n c l u d e d a n i n - d e p t h
of Substance Abuse Counseling, as well as a study of the 12 core functions of the substance abuse counselor. 28.) INTRODUCTION TO THE CANNABIS YOUTH
þÿ T R E A T M E N T S E R I E S T h i s t r a i n i n g i n t r o d u
recognized curriculum designed to be an effective brief treatment approach for cannabis-abusing adolescents. 29.) COMING SOON TO AN AGENCY NEAR YOU! A MAJOR CHANGE IN HOW WE DO ONTO OTHERS; GETTING READY TO BECOME A CERTIFIED CLINICAL
þÿ S U P E R V I S O R T h i s c o u r s e i n t r o d u c e d t h e
overview of critical information needed to successfully complete and pass the ICRC Clinical Supervisor Exam as well as providing a forum for discussing the business of supervision. 30.) HEALING THE HEALER - CREATING NEW FIRE OUT OF
þÿ T H E E M B E R S O F B U R N O U T P a r t i c i p a n t s i d e
that can compromise wellness. Participants also learned to recognize signs and symptoms of burnout. 31.) CROSSING THE BORDER: CLINICAL AND CULTURAL ISSUES
þÿ W I T H H I S P A N I C C L I E N T S T h i s c o u r s e w a s
improving their service delivery efforts with limited English proficiency (L.E.P.) Hispanic population. The course also addressed the cultural and clinical concerns experienced in providing quality treatment and case management services across the language barrier. 32.) ADVANCED GROUP
þÿ C O U N S E L I N G S K I L L S F O R T H E S U B S T A N C E A B U S
combination of didactic and experiential learning. The focus was to learn advanced group facilitation skills, paired with the development of relationships as a way of working with diverse and or difficult populations in a variety of settings. þÿ 3 3 .) S O Y O U H A V E A D E A F C O N S
course looked into the psycho-social implications of hearing loss, with emphasis on working with consumers who are deaf. 34.) MANAGING STRESS IN THE
þÿ W O R K P L A C E T h i s s e s s i o n a d d r e s s e d c o n c e r
of stress in the workplace and ways to reduce or manage stress. 35.)
þÿ A D O L E S C E N T G R O U P T E C H N I Q U E S T H A T R E A L L Y
participants to understand the core theories of group dynamics. 36.) BASIC
þÿ C O U N S E L I N G S K I L L S E i g h t b a s i c c o m m u n i c
paraphrasing, reflection of feelings, summarizing, probing, counselor self disclosure, interpreting and confrontation. All of the fore-mentioned were developed to assist the counselor with their interacting with the individual. 37.) THE SCIENCE OF RECOVERY: APPLYING NEUROPSYCHOLOGY AND NEUROSCIENCE TO YOUR
þÿ P R A C T I C E T h i s s k i l l s t r a i n i n g e v e n t g a
the neuroscience and neuropsychology of addiction and recovery.

Prevention courses offered: 1.) EXPLORING PREVENTION ETHICS FOR THE 21ST
þÿ C E N T U R Y T h i s c o u r s e p r o v i d e d p r e v e n t i o n
decision-making and practice. 2.) HARD CHOICES: PARENTING THE ADOLESCENT
þÿ C H I L D This course examined adolescent behavior in light of current neurological research, and offered practical strategies for modifying self-defeating behaviors. 3.) HIV/AIDS 101 FOR MENTAL
þÿ H E A L T H / P R E V E N T I O N / S U B S T A N C E A B U S E P R O F E S
participants with a foundation of knowledge about HIV/AIDS. 4.) PREPARING FOR
þÿ T H E S U B S T A N C E A B U S E P R E V E N T I O N C E R T I F I C A
learning and practice within the five prevention competency domains covered on the written test (i.e., the IC&RC exam) for certification. 5.) HEPATITIS C:
þÿ W H A T Y O U N E E D T O K N O W . . . T h i s c o u r s e d i
it is treated. þÿ 6 .) T H E A B C S O F S T D S F O R A D D I C
þÿ T h i s c o u r s e p r o v i d e d a n o v e r v i e w o f c u
and management to the lay (non-STD) professional in the counseling and education of individuals living with a dual diagnosis, i.e., alcohol/drug addiction and a sexual transmitted disease/infection including HIV/AIDS. 7.)
þÿ P S Y C H O L O G Y O F A D D I C T I O N T h i s c o u r s e e x a
psychology of human beings, and how this affects drug addiction and other impulse-control disorders.

Current Status: Accomplished. Total attendees: 712

FY 2007 (PROGRESS)

Activity: The Substance Abuse Services Division assisted in the planning and development of courses, and provided scholarships to the annual Southeastern School of Alcohol and Drug Studies, which is held in Athens, Georgia in Oct 2006. Continuing education units were offered.

Courses offered: 1.) Prevention Institute Track 1.) SAVING LIVES: PREVENTING UNDERAGE DRINKING THROUGH ENVIRONMENTAL STRATEGIES AD ENFORCEMENT - This track offered courses all week long around Under Aged Drinking and Environmental Strategies, 2.) MOTIVATIONAL INTERVIEWING - This course helped the participants understand the underlying concepts of Motivational Interviewing 3.) THE GREY DANCE: þÿ C E L E B R A T I N G O U R S P I R I T U A L J O U R participants understand and express their spiritual ideas and concepts. 4.) INNOVATIVE INTERVENTIONS: A NEW MODEL FOR ADDICTION TREATMENT - This was an interactive course involving instruction and role play regarding intervention and assessment 5.) ADVENTURES IN COUNSELING: AN EXPERIENTIAL APPROACH TO GROUP COUNSELING - This was an experimental activities based course that taugh participants to use games and other fun activities to enhance groups. 6.) EFFECTIVE YOUTH TREATMENT MODELS: þÿ Y O U V E G O T M E H E R E , N O W strategies for measuring the effectiveness of program and recruiting and retaining youth in treatment. 7.) SILENT SONS & PERFECT DAUGHTERS: APPRECIATING GENDER DIFFERENCES IN TREATMENT AND RECOVERY - This workshop focused on an appreciation for gender differences in treatment and the recovery process. 8.) CLINICAL SUPERVISION: þÿ S K I L L S F O R T H E F U T U R E the foundation for supervision of personnel. 9.) S.M.A.R.T. TREATMENT PLANNING - This course examined how ASI information can be used for clinical applications. 10.) RELATIONSHIPS, SEXUALITY AND RECOVERY - This course helped professionals improve services to client dealing with relationships and sexual issues. 11.) METHAMPHETAMINES This course presented up to date information on the epidemiology of meth. 12.) CORE ADDICTION TREATMENT SKILLS - This course provided an opportunity for professionals to receive up-to-date educational the delivery of services. 12.)CO-OCCURRING DISORDERS: CHILD AND ADOLESCENT ONSET DISRUPTIVE DISORDERS - This course focused on the interplay between addictive and disruptive disocrder.13.) CULTURALLY COMPETENT SERVICES DELIVERY - This course helped participants identify aspects of culture among staff and clients. 14.) STRATEGIC PREVENTION FRAMEWORK - Participants gained basic understanding of the Strategic Prevention Framework Step 1-5. 15.) DEALING WITH FAMILIES IN þÿ T R E A T M E N T T h i s s e s s i o n a d d r e s s e d t h e c recovery. 16.) DEALING EFFECTIVELY WITH GANGS - This course covered the basics of gangs from the historical perspective. 17.) PREVENTION ETHICS - This course identified standards of conduct for prevention professionals.18.) BEST PRACTICES IN ADDICTION TREATMENT - This course identified a number of current evidenced based practices. 19.) KEYSTONES FOR SUCCESS: ASSETS BASED PROCESS FOR POSITIVE YOUTH DEVELOPMENT - This course taught participants how to identify youth cased assets by examining their own pathways to success. 20.) DRUGS OF ABUSE AND TRAFFICKING TRENDS - This training provided knowledge around recognitions, behavior and psychological and physical signs 22.) HOW TO AVOID FALLING OFF THE WAGON: þÿ R E L A P S E P R E V E N T I O N R E L A P S E P R discussed an alternative view on the nature of relapse. 23). YOUTH ISSUES IN þÿ A D D I C T I O N T R E A T M E N T T h i s c o u r s e h e l p e d core characteristics of resilience. 24.) THE SCIENCE OF RECOVERY: APPLYING þÿ N E U R O S Y C H O L G Y A N D N E U R O S C I E N C E T O Y O U R P an understanding of the neuroscience and neuropsychology of addiction and þÿ r e c o v e r y . 2 5 .) S P E C I A L P O P U L A T I O N S - W O M familiarized the participants with the special challenges and needs of the female substance abuser.

Current Status: Accomplished. Total attendees 398

Activity: The Substance Abuse Services Division assisted in the planning and development of courses, and provided scholarships to the annual Alabama Alcohol

FY 2007 (PROGRESS)
and Drug Abuse Prevention Conference held in Jacksonville AL in Aug. Continuing education units were offered.

Courses offered: 1.) ETHICS FOR PREVENTION SPECIALIST PART- Participants became þÿ f a m i l i a r w i t h t h e I R C R E t h i c a l p r e v e n t i o SUBSTANCE ABUSE DEVELOPMENTAL ISSUES AND FAMILY DYNAMICS - This workshop addressed adolescent substance abuse from a number of perspectives, parenting styles and developmental changes. 3.) EARLY INTERVENTION IN SUBSTANCE ABUSE: þÿ B R I D G I N G P R E V E N T I O N A N D T R E A T M E N T T H I S youth in the justice system that are experiencing drugs. 4.) FAMILY STRENGTHENING WEEKEND - Participant learned the history and purpose of the family strengthening weekend. 6.) ENVIRONMENTAL STRATEGIES - Participants in this group participated in group discussions about how environmental strategies are changing the focus of prevention work. a7.) THINKING OUTSIDE OF THE BOX - This workshop explored innovative youth programs. 8.) MANAGING DISRUPTIVE þÿ A U D I E N C E S T h i s c o u r s e t a u g h t e f f e c t i v e þÿ p r o g r a m s , 9 .) H I V - A I D S F O R P R E V E N T I O N S P of the HIV/AIDS statistics in Alabama and basic facts. 10.) ADVOCACY: þÿ W H A T þÿ T H E M E S S A G E T h i s c o u r s e d i s c u s s e d w a y s þÿ s u b s t a n c e a b u s e r a n d h o e i t i n i t i a t e f u n This course demonstrated techniques use with at risk youth and adult in þÿ t r e a t m e n t s e t t i n g s . 1 2 .) M E T H A M P H E T A M I N E þÿ a d d i c t i o n . 1 3 .) P R E V E N T I O N S C E R T I F I C A T I O þÿ h e l p p a r t i c i p a n t s g e t r e a d y f o r t h e e x a m This course provide effective and easy to implement strategies for engaging ad þÿ e m p o w e r i n g p a r e n t s . 1 5 .) G E T T I N G T H E L A W to pass civil ordinances around addiction. 16.) SPLASHY AND RIPPLE: USING OUTCOMES TO DESIGN AND MANAGE COMMUNITY ACTIVITIES - This course strengthened þÿ t h e p a r t i c i p a n t s a b i l i t y t o w r i t e g o a l s þÿ m e a s u r e o u t c o m e s a n d m a k e c h a n g e s . 1 7 .) examined theory connected to the psychology of human beings, and how this affects drug addiction and other impulse-control disorders.

Current Status: Accomplished Total attendees 95.

FY 2008 (INTENDED)
The Substance Abuse Services Division will provide continuing education and continuing education units for the employees of facilities which provide prevention activities and treatment services.
SASD will partner with the Alabama Alcohol and Drug Abuse Association to provider continuing education units for all trainings. In order to address the workforce needs SASD has a position on the following boards; Alabama Alcohol and Drug Abuse Association (certifies treatment and prevention professional), Alabama School for Alcohol and Other Drug Studies, Appalachian School of Alcohol and Other Drug Studies and Southern Coast ATTC. These board positions allow SASD to participate in the planning and development of conferences to address the workforce needs of the treatment and prevention professionals across the state. The goal of SASD is to offer prevention and treatment courses at every conference. The Office of Certification and Training conducted a treatment and prevention workforce survey in conjunction with SCATTC. A SASD Workforce Committee has been formed and have begun to work on a workforce plan for the SASD.

Activity: The Substance Abuse Services Division will assist in the planning, participate in the conducting and provide scholarships to the annual Alabama School of Alcohol and Drug Studies, which will be held in Tuscaloosa, Alabama in March.

Activity: The Substance Abuse Services Division will assist in the planning, participate in the conducting and provide scholarships to the Annual Alabama Alcohol and Drug Abuse Association annual treatment conference held Oct. Locations and dates are yet to be determined.

Activity: The Substance Abuse Services Division will conduct training for substance abuse program staff in various locations throughout the State. Topics include case management, best practices approaches, adolescent treatment, psychosocial assessment, treatment planning, etc. Dates to be determined.

Activity: The Substance Abuse Services Division will assist in the planning, participate in the conducting and provide scholarships to the Annual Alabama Alcohol and Drug Abuse Association annual prevention conference held in Jacksonville AL in Aug.

Alabama

Goal #12: Coordinate Services

GOAL # 12. An agreement to coordinate ,prevention activities and treatment services with the provision of other appropriate services (See 42 U.S.C. 300x-28(c) and 45 C.F.R. 96.132(c)).

FY 2005 (Compliance):

FY 2007 (Progress):

FY 2008 (Intended Use):

FY 2005 (COMPLIANCE)
FY 2005 (Compliance):

Activities:

The Substance Abuse Services Division will provide HIV prevention and educational services for the Alabama Correctional System in all pre-release settings.

Prevention workers will provide training to other health care providers on substance abuse signs, symptoms, etc.

Family-strengthening programs will be offered to families with a member in treatment.

High risk youth identification and education services will be provided to those individuals referred by the Department of Youth Services, school counselors, juvenile judges, the Department of Human Resources, etc.

Summer alternative programs will be provided to high-risk youth. Summer alternative programs are available within each of the four service regions of the state.

Results:

The SASD contracted with thirty-five community providers for the provision of prevention activities including; HIV prevention education, training for health care providers, family-strengthening, high risk youth identification and education programs, and summer alternative programs. These services were provided to individuals referred from the Alabama Correctional System, health care providers, Department of Youth Services, school counselors, juvenile judges, and the Department of Human Resources. Appropriate prevention activities are coordinated through cooperative agreements with the previously mentioned local agencies.

Statewide collaborative efforts to coordinate substance abuse prevention and treatment services include the Alabama Commission for the Prevention and Treatment of Substance Abuse. The SASD, Associate Commissioner for Substance Abuse, chairs the Alabama Commission which was created by Executive Order #23. The Commission was created to accomplish the following.

1. Support the efforts of the Alabama Department of Mental Health and Mental Retardation in fulfilling its statutory mandate to supervise, coordinate, and establish standards for all operations and activities of the State of Alabama related to alcoholism and drug addiction;

2. Recommend initiatives to minimize the impact of substance abuse and addiction in Alabama;

3. Identify areas of interrelationship and opportunities for collaboration between substance abuse prevention, treatment, education, health and enforcement programs and resources, and

4. Develop formal policies and procedures for coordination and efficient utilization of programs and resources.

The following state agencies are included in Executive Order #23 as members of the Alabama Commission.

Department of Public Health
Department of Education

FY 2005 (COMPLIANCE)
Office of the Attorney General
Medicaid Agency
Department of Human Resources
Department of Children Affairs
Department of Rehabilitation
Department of Corrections
Department of Youth Services
Department of Senior Services
Department of Public Safety
Alcoholic Beverage Control Board
Board of Pardons and Paroles
Department of Economic and Community Affairs
þÿ G o v e r n o r s O f f i c e o f F a i t h B a s e d a n d C
Administrative Office of Courts
Council of Community Mental Health Boards
Association of Addiction Counselors
Alabama Recovery Network
Department of Mental Health and Mental Retardation
Representative of the Alabama House of Representatives
Representative of the Alabama Senate
Office of the Governor
Recovering substance abuse consumer

The 2005 Alabama Commission Report to the Governor is attached.

FY 2007 (PROGRESS)
FY 2007 (Compliance):

Activities:

The Substance Abuse Services Division will provide HIV prevention and educational services for the Alabama Correctional System in all pre-release settings.

Prevention workers will provide training to other health care providers on substance abuse signs, symptoms, etc.

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Department of Education

FY 2007 (PROGRESS)
Office of the Attorney General
Medicaid Agency
Department of Human Resources
Department of Children Affairs
Department of Rehabilitation
Department of Corrections
Department of Youth Services
Department of Senior Services
Department of Public Safety
Alcoholic Beverage Control Board
Board of Pardons and Paroles
Department of Economic and Community Affairs
þÿ G o v e r n o r s O f f i c e o f F a i t h B a s e d a n d C
Administrative Office of Courts
Council of Community Mental Health Boards
Association of Addiction Counselors
Alabama Recovery Network
Department of Mental Health and Mental Retardation
Representative of the Alabama House of Representatives
Representative of the Alabama Senate
Office of the Governor
Recovering substance abuse consumer

The 2005 Alabama Commission Report to the Governor is attached.

The Alabama Commission continues to strive to implement the recommendations included in the 2005 Report to the Governor. Implementation of the recommendations in other state agencies has been delayed due to the þÿ c o m p l i c a t i o n s o f i m p l e m e n t i n g a c o m p l e t e Alabama Department of Mental Health. þÿ M a j o r p o r t i o n s o f t h e þÿ I m p r o v e m e n t I n i t i a t i v e a P a r t i a l i m p l e m e n t a t i o n i s n g scheduled for SFY 2007-2008.

The following are examples of specific agency partnerships but is not intended to be all inclusive.

The SASD partners with the Alabama Board of Pardons and Parole to provide treatment services for adult parolees at a female facility in Wetumpka and a male facility in Thomasville.

The SASD partners with the Administrative Office of Courts to implement the number one goal of the Chief Justice of the Supreme Court, to establish Drug Courts in every county of Alabama by 2010.

The SASD partners with the Department of Corrections regarding the development of an Aftercare Plan for inmates.

FY 2008 (INTENDED USE)
FFY 2008 (Intended Use):

The SASD will continue the efforts of the Alabama Commission, including the þÿ f u l l i m p l e m e n t a t i o n o f t h e S y s t e m I m p r o agencies involved with citizens suffering with substance abuse and addiction.

Goal #12: Coordinate Services Footnotes
THE ALABAMA COMMISSION

FOR THE

PREVENTION AND TREATMENT

OF

SUBSTANCE ABUSE

2005 Annual Report

Presented to Governor Bob Riley

TABLE OF CONTENTS

January, 2006

Honorable Bob Riley
Governor of Alabama

Dear Governor Riley:

On behalf of the members of the Alabama Commission for the Prevention and Treatment of Substance Abuse, I thank you for your insight, leadership and

support in signing Executive Order #23, which created the Commission. I also acknowledge the dedication of the Commission members, without whose diligence this report would not have been possible.

This Annual Report represents the collective efforts of all the Commission members provided through Commission meetings, small workgroups, phone conferences, and emails. The report represents an excellent beginning for the þÿ s u b s t a n c e a b u s e S y s t e m The initiatives will improve it substance abuse prevention and treatment services for all citizens of Alabama, regardless of the state agency initially contacted. The Commission has identified numerous long-range recommendations and specific actions for 2006 that will improve the efficiency and effectiveness of available resources for substance abuse prevention and treatment services. While demand outpaces resources for the prevention and treatment of substance abuse, the Commission focused on enhancing the utilization of current resources. Therefore, following accomplishment of the improvement initiatives, the Commission will confidentently request additional resources necessary to address the gap between the demand for services and the available resources.

Cognizant that substance abuse impacts thousands of lives through every state agency; the Commission appreciates the opportunity to offer these þÿ r e c o m m e n d a t i o n s f o r i m p r o v e m e n t i n A l a b a treatment system.

Sincerely,

J. Kent Hunt, Chairman
Alabama Commission for the Prevention and Treatment
of Substance Abuse

ALABAMA COMMISSION FOR THE PREVENTION AND TREATMENT OF SUBSTANCE ABUSE

MEMBERSHIP

Dr. Sue Adams
Department of Education

Dr. Paul Bisbee
Department of Mental Health and Mental Retardation

Ms. Jan Byrne
Alcoholic Beverage Control Board

Dr. Ron Cavanaugh
Department of Corrections

Ms. Glenda Deese
Department of Public Safety

Ms. Callie Dietz
Administrative Office of the Courts

Dr. Jim Dill
Alabama Council of Community Mental Health Boards

Mr. Richard Dorrough

Goal #12: Coordinate Services Footnotes
þÿ D e p a r t m e n t o f C h i l d r e n s A f f a i r s

Honorable Vivian Figures
Alabama Senate

Honorable Blaine Galliher
Alabama House of Representatives

Ms. Carie Gancy
Department of Senior Services

Ms. Dollie Hambrick
Department of Public Health

Ms. Sarah Harkless
Department of Mental Health and Mental Retardation

Ms. Terri Hasdorff
þÿ G o v e r n o r s O f f i c e o f F a i t h - B a s e d a n d C o m

Mr. Kent Hunt
Department of Mental Health and Mental Retardation

Ms. Eileen Jones
þÿ G o v e r n o r s A p p o i n t e d A d v o c a t e

Mr. Bill Layfield
Alabama Voices for Recovery

Ms. Eranell McIntosh-Wilson
Department of Mental Health and Mental Retardation

Ms. Christina McLemore
Alabama Alcohol and Drug Abuse Association

Mr. Gary Mitchell
Department of Human Resources

Mr. Carl Nowell
Department of Rehabilitation Services

Mr. Bill Segrest
Board of Pardons and Paroles

Ms. Lynn Sharp
Medicaid Agency

Mr. Kenneth Steely
Office of the Attorney General

Ms. Mary Lou Street
Alabama Counselors Association

Mr. Kris Vilamaa
Department of Economic and Community Affairs

Mr. Walter Wood
Department of Youth Services

Goal #12: Coordinate Services Footnotes

þÿ I n a c c o r d a n c e w i t h E x e c u t i v e O r d e r # 2 3 ,
þÿ c o m m i t m e n t t o i m p l e m e n t a w o r k a b l e s u b s t
þÿ I n i t i a t i v e t h a t w i l l p r o v i d e r e a l b e n e f

In 2006, the Commission will implement the following actions and recommendations:

1. The Commission will meet at least six times and submit an annual report to the Governor by November 30, 2006. The Commission will meet in January, March, May, July, September and November, 2006.

2. A single point of contact (clearinghouse) for substance abuse information and referral will be developed. State agency specific information will be available for substance abuse services through one phone number and/or web site. The single point of contact process will be implemented by November 30, 2006.

3. The State Incentive Grant (SIG) Advisory Committee, as a permanent workgroup of the Commission, will implement the Strategic Prevention Framework (SPF) designed to guide all state agency supported substance abuse prevention activities to assess prevention needs, determine capacity to meet the identified needs, plan effective strategies for application, implement the selected strategies and evaluate the outcomes. All state agency supported prevention activities will be operating according to SPF guidelines by October 1, 2006.

4. A uniform substance abuse screening, assessment, and level of care determination process will be developed and adopted for use by all state agencies by October 1, 2006.

5. A uniform definition of services will be developed and adopted by all state agencies by October 1, 2006.

6. A uniform set of programmatic and staffing standards will be developed by October 1, 2006 and implemented by all state agencies by December 31, 2006.

7. The Alabama Department of Mental Health and Mental Retardation will begin certifying all substance abuse prevention and treatment programs (services) provided through all state agencies by December 31, 2006.

8. A uniform rate structure will be developed for all substance abuse services. The rate structure will include client clinical and financial eligibility criteria. The uniform rate structure will be adopted by all state agencies by December 31, 2006.

9. A client record process which allows appropriate clinical information to
þÿ f o l l o w t h e i n d i v i d u a l m o v i n g t h r o u g h t h e
agency) will be developed by November 30, 2006.
10. A uniform outcome measurement process which allows for evaluation of the
þÿ s e r v i c e s a s t h e i n d i v i d u a l p r o g r e s s e s t h
agency to agency) will be developed by November 30, 2006.

þÿ T h e u l t i m a t e g o a l o f t h e s u b s t a n c e a b u s e
all state agency sponsored substance abuse prevention and treatment services to be as accessible, effective and efficient as possible. Through the accomplishment of this goal, individuals can experience positive life changes; resulting in reduced substance use, reduced criminal behavior, increased employment, increased safe housing, improved general health and improved family relationships.

Goal #12: Coordinate Services Footnotes

This report represents the combined efforts of many and would not have been possible without initial financial, technical and moral support from the Robert Wood Johnson Foundation, Resources for Recovery Project. Alabama received a grant through the Resources for Recovery Project that proved to be the impetus þÿ t o g e t t h i s S y s t e m s I m p r o Consultative Support at essential in establishing the Commission, publishing this report and developing collaborative interagency relationships. From these beginnings, it became obvious that only through continued collaboration amongst state agency representatives would substantive improvement in the substance abuse prevention and treatment system in Alabama be achieved.

The Substance Abuse and Mental Health Services Administration (SAMHSA) through the Center for Substance Abuse Prevention (CSAP) and the Center for Substance Abuse Treatment (CSAT) also contributed to these efforts. Both CSAP and CSAT are major funding sources for substance abuse prevention and treatment services in Alabama. Through the Substance Abuse Prevention and Treatment Block Grant, þÿ S A M H S A c o n t r i b u t e s a p p r o x i m a t e l y $ 2 4 m i l combating substance abuse and addiction. SAMHSA has developed strategic plans assisting states to improve substance abuse prevention and treatment services. The prevention plan is the Strategic Prevention Framework (SPF) and the treatment plan is described in Improving Substance Abuse Treatment: The National Treatment Plan (NTP) .

The SPF is designed to expand state capabilities in assessing prevention needs, determining ability to meet identified needs, planning effective strategies for application, implementing selected strategies and evaluating outcomes of services on prioritized populations. Alabama received a State Incentive Grant (SIG) designed to financially support state adoption and implementation of SPF. Governor Bob Riley created the Alabama State Incentive Grant Advisory Committee to implement SPF. This advisory group served as the prevention work group for the Commission, with prevention recommendations coordinated between the Commission, SPF and the State Incentive Grant Advisory Committee.

þÿ T h e C e n t e r f o r S u b s t a n c e A b u s e T r e a t m e n Plan Initiative (NTP) in the fall of 1998, to provide an opportunity for the field to reach a working consensus on how best to improve substance abuse treatment, and then to pursue action to effect needed change. The NTP is not þÿ d e s i g n e d t o c r e a t e a t r a d i t i o n a l n a t i o n Rather, it is intended to provide a common starting point, to engage people throughout the field in a collaborative effort, and to recommend the types of guidelines and actions that over time can lead to the goal of making effective þÿ s u b s t a n c e a b u s e t r e a t m e n t a v a i l a b l e t o a

The NTP identified five guidelines that are essential to improving substance abuse services.

1. þÿ I n v e s t F o The wise use of resources requires investment in þÿ t r e a t m e n t s e r v i c e s t h a t i n t u r n m u s t p r o
2. þÿ N o W r o n g D o o r Effective systems must ensure that an individual needing treatment will be identified and assessed and will receive treatment, either directly or through appropriate referral, no matter where he þÿ o r s h e e n t e r s t h e r e a l m o f s e r v i c e s .
3. þÿ C o m m i t T E f f e c t i v e Quality treatment and the wise use of resources þÿ d e p e n d u p o n o n g o i n g i m p r o v e m e n t i n t h e q
4. þÿ C h a n g e A S i g n i f i c a n t Reduction in stigma and changes in þÿ a t t i t u d e s w i l l r e q u i r e a c o n c e r t e d e f f o r
5. þÿ B u i l d P a r E f f e c t i v e Efforts by individuals and organizations throughout the substance abuse treatment field to work with each other and with

the many other people and groups throughout society who share a concern to improve substance abuse treatment will require specific encouragement and þÿ s u p p o r t .

Both of these national strategies are designed to assist states in providing effective and coordinated substance abuse prevention and treatment services targeted to areas and populations of greatest need.

The Alabama Commission for the Prevention and Treatment of Substance Abuse proposes a similar approach for the State of Alabama. The Commission provides an opportunity for state agencies to reach a working consensus on improving substance abuse prevention and treatment programs and services. The Commission engages agencies in a collaborative effort by developing guidelines and actions leading to the provision of effective prevention and treatment services for every citizen in need, regardless of which state agency is contacted first.

The Commission regards this report as the beginning of a long-term effort to engage the attention and energy of people throughout the state.

INTRODUCTION

All state agencies serve citizens at risk or already suffering from substance abuse or addiction. Substance abuse and addiction have surfaced as common threads woven into the lives of thousands of Alabama citizens. Substance abuse co-occurs with health related issues, employment, education, involvement in the criminal justice system, child custody and rehabilitation. The problems associated with substance abuse have become so overwhelming that many agencies have created prevention and treatment services to address the needs of their þÿ c u s t o m e r s . These services are supported by a variety of means, including federal, state and/or private funding sources. Unfortunately, there are still not enough resources available to meet current demands for substance abuse services in Alabama. þÿ I n r e s p o n s e t o t h e s e n e e d s , t þÿ I m p r o v e m e n t I n i t i a t i v e w a s t h e c r e a t i o n o f Prevention and Treatment of Substance Abuse.

Executive Order #23, dated September 29, 2004, established the Alabama Commission for the Prevention and Treatment of Substance Abuse. The executive order includes the following strategies designed to increase the efficiency, effectiveness and accountability of all state funded programs, regardless of which state agency provides oversight.

1. Coordinate programs and resources that address substance abuse issues;
2. Increase public awareness about the chronic nature of addiction;
3. Invest in evidence-based prevention and treatment strategies;
4. Improve access to treatment for current abusers; and
5. Place responsibility for managing state substance abuse-related investments in a single state agency.

The following specific charges were issued to Commission members.

1. Support the efforts of the Alabama Department of Mental Health and Mental Retardation in fulfilling its statutory mandate to supervise, coordinate, and establish standards for all operations and activities of the State of Alabama related to alcoholism and drug addiction;
2. Recommend initiatives to minimize the impact of substance abuse and addiction in Alabama;

Goal #12: Coordinate Services Footnotes
3. Identify areas of interrelationship and opportunities for collaboration between substance abuse prevention, treatment, education, health, and enforcement programs and resources; and
4. Develop formal policies and procedures for coordination and efficient utilization of these programs and resources.

þÿ T h i s r e p o r t d e s c r i b e s t h e s u b s t a n c e a b u s
which is a combination of the strategies and charges of Executive Order #23, the Strategic Prevention Framework (SPF) and the National Treatment Plan (NTP). In Section I, the Commission presents long-range recommendations increasing access to substance abuse services, improving effectiveness and efficiency of those services and paving the way towards attitudinal change of the general citizenry regarding substance abuse prevention and treatment services. Section II identifies the specific actions that will be taken during 2006.

SECTION I: RECOMMENDATIONS

Commission members served on work groups charged with the development of specific recommendations for improving substance abuse services offered through state agencies in Alabama. The work groups were Criminal Justice, Prevention, and Treatment. þÿ T h e r e c o m m e n d a t i o n s a r e l o n g - r a n
substance abuse prevention and treatment that is accessible, responsive to client needs and scientifically based.

CRIMINAL JUSTICE

CJ1. Institute a permanent state level substance abuse steering committee charged with meeting the needs of all clients and providers.
CJ2. Develop an overview of all state agency substance abuse activities, missions, and functions and distribute to agencies, legislative oversight/advisory committees and the public.
CJ3. Fill in geographic gaps where no substance abuse treatment/prevention is available in the state.
CJ4. Develop collaboration between the correctional institutions and community support systems to include transfer of individual care plans, assessments completed while within the institutions and coordination of local continuing care resources.
CJ5. Prioritize continuing care/after care for released inmates.
CJ6. Increase state funding for substance abuse prevention and treatment.
CJ7. Implement budgeted long range strategic planning specifically identifying substance abuse resources.
CJ8. Target resources to treatment on the local level including juvenile þÿ m e n t a l h e a l t h s e r v i c e s , c o u r t r e f e r r e d s
families. (Gap refers to economic stratification resulting in too much income to qualify for services and too little income to afford services.)
CJ9. Develop an outreach program to secure partner funding from county commissions for deferred treatment/drug courts.
CJ10. Institutionalize substance abuse education and training for all law enforcement personnel and elected officials (to include the executive, legislative, and judicial).
CJ11. Develop and implement a public information and education plan on substance abuse issues and state agency substance abuse related functions.

PREVENTION

P1. Implement a common framework for all state substance abuse prevention funding sources that also aligns to the standard federal applications for similar programs.

Goal #12: Coordinate Services Footnotes

P2. Construct a substance abuse prevention system that is built on the foundation of a single state coalition, composed of a mix of state agencies and local preventionists, that works in concert with all varieties of local coalitions representing substance abuse prevention stakeholders in the community.

P3. Develop a long-range comprehensive state plan for alcohol, tobacco and other drug abuse prevention.

P4. Develop a statewide program that offers incentives (i.e. paying for higher education) to Alabama youth who sign a pledge to remain drug-free, submit to random drug testing and subsequently stay drug-free.

P5. Analyze the current allocation of resources and documented substance abuse rates to determine if resources are reaching areas in need.

P6. Examine procedures for accessing funds once grants are awarded and consider adopting a resource distribution method similar to the federal government, which allows for electronic or telephonic transfer of funds.

P7. Examine the issue of certification in the field of substance abuse prevention and the feasibility of developing a policy on certification and training that would apply across all agencies that distribute funds for substance abuse prevention.

P8. Increase the amount of time between grant training and application due dates (at least ninety days).

P9. Involve youth in state and local prevention coalitions.

P10. Increase the effort in the area of cultural competency to bring training to all areas of the substance abuse prevention field.

P11. Increase the amount of training offered to parents at the state and local level.

P12. Encourage the sharing of successful parental training efforts.

P13. Adopt a single definition of prevention for Alabama.

P14. Encourage greater use of technology to disseminate information.

P15. Publicize and celebrate effective prevention efforts.

P16. Encourage local, cohesive structures and systems.

TREATMENT

T1. Increase the number of bi-lingual speaking substance abuse counselors and therapists.

T2. Expand access to substance abuse services by requiring uniform rates, income eligibility, sliding fee scales and encouraging expanded coverage of substance abuse treatment services by health insurance companies (parity).

T3. Develop certification standards for every level of substance abuse treatment and require all substance abuse treatment programs to comply.

T4. Consistently educate judges regarding appropriate assessment and level of

care determination for substance abuse treatment services.

T5. Develop and adopt a statewide uniform substance abuse screening, assessment and level of care determination process.

T6. Develop and adopt uniform priority populations to be served, i.e. women and dependent children.

T7. Implement a single 1-800 number for access to substance abuse services.

T8. Develop and implement uniform substance abuse treatment staff training, credentials and competency requirements.

T9. Require the use of science/evidenced-based practices in every certified substance abuse treatment program.

T10. Develop and implement a statewide outcome measurement process required for all certified substance abuse treatment programs.

T11. Develop and implement a substance abuse stigma reduction campaign.

T12. Develop and implement a process to encourage increased local county and city financial support for substance abuse treatment services.

T13. Analyze the appropriate process for serving citizens who are court ordered to substance abuse treatment when they have no desire to be treated.

T14. Identify Legislators interested in becoming involved in advocacy for substance abuse treatment.

T15. Adopt, encourage and train substance abuse treatment programs in the individualized treatment approach.

T16. Develop and implement substance abuse continuing education for professionals including: judges; legislators; nurses; doctors; ministers, etc.

T17. Define and implement a continuum of care that is
ience/evidenced-based.

SECTION II: 2006 ACTIONS

In 2006, the Commission will implement the following actions and recommendations:

1. The Commission will meet at least six times and submit an annual report to the Governor by November 30, 2006. The Commission will meet in January, March, May, July, September and November, 2006.

2. A single point of contact (clearinghouse) for substance abuse information and referral will be developed. State agency specific information will be available for substance abuse services through one phone number and/or web site. The single point of contact process will be implemented by November 30, 2006.

3. The State Incentive Grant (SIG) Advisory Committee, as a permanent workgroup of the Commission, will implement the Strategic Prevention Framework (SPF) designed to guide all state agency supported substance abuse prevention activities to assess prevention needs, determine capacity to meet the identified needs, plan effective strategies for application, implement the selected strategies and evaluate the outcomes. All state agency supported

Goal #12: Coordinate Services Footnotes
prevention activities will be operating according to SPF guidelines by October 1, 2006.

4. A uniform substance abuse screening, assessment, and level of care determination process will be developed and adopted for use by all state agencies by October 1, 2006.

5. A uniform definition of services will be developed and adopted by all state agencies by October 1, 2006.

6. A uniform set of programmatic and staffing standards will be developed by October 1, 2006 and implemented by all state agencies by December 31, 2006.

7. The Alabama Department of Mental Health and Mental Retardation will begin certifying all substance abuse prevention and treatment programs (services) provided through all state agencies by December 31, 2006.

8. A uniform rate structure will be developed for all substance abuse services. The rate structure will include client clinical and financial eligibility criteria. The uniform rate structure will be adopted by all state agencies by December 31, 2006.

9. A client record process which allows appropriate clinical information to þÿ f o l l o w t h e i n d i v i d u a l m o v i n g t h r o u g h t h e agency) will be developed by November 30, 2006.

10. A uniform outcome measurement process which allows for evaluation of the þÿ s e r v i c e s a s t h e i n d i v i d u a l p r o g r e s s e s t h agency to agency) will be developed by November 30, 2006.

11. Beginning on October 1, 2007 all state agency supported substance abuse þÿ p r e v e n t i o n a n d t r e a t m e n t s e r v i c e s m u s t m criteria.

SECTION III: SUMMARY

þÿ T h e s e a c t i o n s s i g n i f y A l a b a m a s c o m m i t m e þÿ a b u s e S y s t e m I m p r o v e m e n t I n i t i a t i v e , t Alabama citizens.
þÿ A l a b a m a s S y s t e m I m p r o v e m e n t I n i t i a t i v e SPF and the NTP.

The action steps address the SPF by specifically training prevention service providers in the areas of assessment, planning, implementation and evaluation. As a result, prevention activities will become more science/evidenced-based, effective and efficient.

The action steps specifically address the NTP by:

1. Investing in services that yield positive change in the lives of the recipients.
2. Assuring that citizens get the same effective treatment service regardless which state agency they contact first.
3. Committing to the same quality service regardless which state agency provides the treatment service.
4. Building partnerships among the state agencies that include the adoption of the common goal of providing the most effective and efficient treatment services possible.

þÿ T h e u l t i m a t e g o a l o f t h e s u b s t a n c e a b u s e all state agency sponsored substance abuse prevention and treatment services to

Goal #12: Coordinate Services Footnotes
be as accessible, effective and efficient as possible. Through the accomplishment of this goal, individuals can experience positive life changes; resulting in reduced substance use, reduced criminal behavior, increased employment, increased safe housing, improved general health and improved family relationships.

Alabama

Goal #13: Assessment of Need

GOAL # 13. An agreement to submit an assessment of the need for both treatment and prevention in the State for authorized activities, both by locality and by the State in general (See 42 U.S.C. 300x-29 and 45 C.F.R. 96.133).

FY 2005 (Compliance):

FY 2007 (Progress):

FY 2008 (Intended Use):

FY 2005 (COMPLIANCE)
FFY 2005 (Compliance):

The Community Resource Assessment (CRA) study used software to produce an internet survey program. DATACORP pilot tested the Internet Survey among 10 participants. DATACORP selected 9 state providers to complete the survey. After the completion of the pilot, the state completed the statewide survey.

The Social Indicator Study required extensive research and planning to ensure methodologically sound study that accurately depicted and interpreted the risk and protective factors in the state of Alabama. An extensive literature review was performed. Analysts at DATACORP conducted a thorough and up to date review of the risk and protective factors and on social indicators. The literature review included a review of the needs assessment studies conducted by other States such as Massachusetts, New York, and the Six State Consortium. It also included a review of the literature addressing Alabama specifically, so that the State and DATACORP would be able to interpret study findings. These findings were disseminated throughout the state to community providers and other community stakeholders.

FY 2007 (PROGRESS)
FFY 2007 (Progress):

The needs assessment data for prevention planning in Alabama was identified from the following sources: the Alabama Pride Survey; the Alabama Social Indicators of Prevention Need; the Alabama Student Survey of Risk and þÿ P r o t e c t i v e F a c t o r s ; t h e C o m m u n i t y R e s o u r þÿ P o l i c y C o u n c i l s N e e d s A s s e s s m e n t s .

The Alabama Pride Survey

The Alabama Pride Survey is the primary source for needs assessment data used for prevention planning in Alabama. The Pride Survey for grades 6-12 was first developed in 1980 with field testing and revisions occurring until 1982 when the questionnaire and associated survey procedures were introduced to Pride customers. The purpose of the Pride Survey and associated survey services was to provide schools and communities with a low cost means to obtain quality information about the prevalence and patterns of drug and alcohol use for their adolescents. Since 1982, more than seven million students have responded to the Pride Survey in communities throughout the United States and in eight foreign countries.

The Pride Survey for Grades 6-12 has been modified over the years to reflect research in this field and the changing informational needs of parents, school officials and other concerned community leaders. Changes in the survey have also reflected national concerns with drug and alcohol use among school-age students, such as nationally reported "risk factors." In addition to modifications in the questionnaire form, survey procedures and reporting results have been refined over the years to not only improve the quality of data collected, but to make it more usable to Pride clients. Survey procedures include directions for pre-survey preparation, administering the questionnaires, collecting questionnaires, and returning the questionnaires to Pride for processing. Reports sent to clients present survey findings in easily understood charts, graphs and "bullet" statements as well as comprehensive percentage tables.

As with any survey, it is important that the data collected are of high quality and utility. The Pride Surveys Questionnaire was developed to provide accurate, reliable and useful information about students through their reported behaviors, perceptions and living environments. Questionnaire forms and administration procedures have undergone extensive reviews by independent evaluators over the years. In 1987, Craig and Emshoff authored a Pride Technical Report called the Pride questionnaire for grades 6-12, a developmental study. Craig and Emshoff addressed the validity and reliability of data collected by the questionnaire using procedures and services developed by Pride research staff. Their report was also reviewed by Dr. Harry Bowman, Office of Educational Research at Memphis State University. Another technical report by Dr. Leroy Metze, Director of Educational Technology at Western Kentucky University was done using the questionnaire used for the 1993-94 school year. Craig and Emshoff discussed the concepts of validity in general and with regard to the Pride Questionnaire. One of the methods to establish validity utilized in the 1987 developmental study was to compare findings between like studies utilizing different instruments to measure the same constructs. Craig and Emshoff utilized data from NIDA sponsored surveys conducted by the Institute for Social Research located at the University of Michigan to compare with data obtained from the Pride Survey. Similarly, Metze compared findings of Pride and the NIDA studies conducted by the Institute for Social Research for the 1991-92 and 1992-93 school years. A major difference from the comparisons by Craig and Eroshoff was the addition of 8th and 10th grade findings, previously not available from the NIDA surveys.

The contrast of Pride and NIDA survey findings produced striking similarity

between both estimates of drug use patterns of drug use. The Pride estimates were slightly higher than NIDA estimates for cigarette and hallucinogen use and estimates were slightly higher than Pride estimates for alcohol and marijuana use. The comparison of 1991-92 and 1992-93 data produced patterns of use that were very similar. Pride and NIDA show statistically significant increases in cigarette smoking at 12th grade level. Neither found statistically significant increases alcohol use at any level. Statistically significant increases in marijuana use were found at all three grade levels by both Pride and NIDA. A statistically significant increase in hallucinogens was found by Pride and NIDA for 12th grade students. Although the sampling, methods for data collection, and instruments were different, there was a remarkable similarity between findings for the Pride national summary data and the NIDA studies. The similarity of findings supports the validity of the Pride Survey and associated survey procedures.

The Alabama Pride Survey was administered in public schools in all 67 counties in Alabama during the following school years: 2002-2003; 2003-2004; 2004-2005; 2005-2006. In 2004-2005, 263,944 students in public schools in Alabama completed the Pride Survey. In 2005-2006, 258,648 students in public schools in Alabama completed the Pride Survey.

The Alabama Social Indicators of Prevention Need; the Alabama Student Survey of Risk and Protective Factors; the Community Resource Assessment

þÿ A s p a r t o f t h e S t a t e o f A l a b a m a s e f f o r t
assessment, three projects were completed: 1.) the Alabama Social Indicators of Prevention Need; 2.) the Alabama Student Survey of Risk and Protective Factors; and 3.) the Community Resource Assessment.

The Alabama Social Indicators of Prevention Need was conducted in 2002 to provide measures of adult and youth substance abuse prevention needs in each county. This study identified indicators from a recommended list provided by the Center for Substance Abuse Prevention (CSAP) to assess community-related aspects of risk and prevention. Example indicators included rates of drug and alcohol arrests, adolescent pregnancies, alcohol sales permits, food stamp recipients, and church organizations. The purpose of the social indicator project was to provide planners and services providers with objective data to
þÿ b e t t e r d e t e r m i n e t h e s t a t e w i d e a n d l o c a l

The Alabama Student Survey of Risk and Protective Factors was conducted in 2002 to provide self-reported data on substance use and other behaviors. The survey was administered to 96,000 adolescents across the state to assess factors such as community rewards, religiosity, transition and mobility, antisocial behavior, and depression. The survey used for this study was created by CSAP by a group of six states in collaboration with the Social Development Research Group at the University of Washington. No substantive modifications were made to this survey and it measures youth substance use, including alcohol, tobacco, marijuana, LSD/hallucinogens, cocaine/crack, and inhalants. The survey also measured risk and protective factors for substance use using four domains: peer/individual, family, school, and community.

The Community Resource Assessment was conducted to evaluate prevention services among programs funded by the Substance Abuse Services Division of the Alabama Department of Mental Health and Mental Retardation during fiscal year 2000.
þÿ P r o g r a m s e v a l u a t e d r e c e i v e d f u n d i n g f r o m
Risk Youth Grant, and/or the Substance Abuse Prevention and Treatment Block Grant. This study inventoried and assessed prevention resources among providers throughout the state using the Core Constructs for Community Resource Assessment, a standard instrument used for all community resource assessments in the CSAP Prevention Needs Assessment program.

The central purpose of all three projects was to compare services provided with

services needed. The Alabama Social Indicators of Prevention Need and the Alabama Student Survey of Risk and Protective Factors were used to provide data on need and the Community Resource Assessment was used to provide data on services provided.

þÿThe Children s Policy Councils Needs As

þÿChildren s Policy Councils were establis
2000 (Code of Alabama §12-15-133) to assess the needs of children and build relationships between community organizations and other interest groups that promote the well-being of children. The ultimate goal for the creation of the Children's Policy Council system was to mobilize providers of services for children and involve them working collaboratively to develop a community service plan which addresses the needs of children (ages 0 to 19). By empowering community decision makers with necessary knowledge and a coordinated plan, problematic issues regarding children can be resolved. The county
þÿChildren s Policy Council is chaired by
mandated members plus seven members at-large. The legislative mandate of the
þÿChildren s Policy Council is to meet at
procedures for children's services, to identify gaps in services, to encourage agency collaboration in order to avoid duplication of services, to conduct an annual needs assessment for the needs of children in the community and to maintain a list of local resources for children's services for their county. The membership of the CPC is a diverse cross section of public and private
þÿindividuals interested in improving chil

þÿEach Children s Policy Council is respon
important issues affecting children in six categories: health; safety; education; economic security; early care and education; and parent involvement and skills. These issues are described in the annual needs assessment for each county and are used for policy recommendations and establishing priorities for
þÿeach county s Childr The needs assessment serves several l.
very important purposes. It fulfills a legal responsibility of both the county
þÿChildren s Councils and the It Alaba
serves as an avenue for the counties and state to identify the issues that are affecting children's lives and ability to grow into productive citizens. It also gives the members of the council a link to policy makers in Montgomery, Alabama and Washington, DC. Needs assessments are reviewed by agencies and legislators to learn what is needed and where priorities should be placed.
þÿAdditionally, Children s Policy Councils
valuable benefit of the Needs Assessment is the local communication and planning that it fosters.

Alabama law requires that Children's Policy Councils submit their needs assessments by July 1st of each year and that the Alabama Children's Policy Council prepare this compiled report by October 1. The Department of Children's Affairs utilized a standardized list of descriptions to label and compare the county issues and priorities. Reports are prepared for several state agencies with the policy recommendations from the councils that are
þÿrelevant to those agencies missions. The
work with the counties and agencies on many of these recommendations to build better communication and facilitate positive outcomes

The format of the needs assessment was developed by a committee of county
þÿChildren s Policy Councils repr It is designed iv
to promote discussion in a broad range of categories that affect children's lives, provide information to state agencies, and serve as a starting point for a strategic plan. The needs assessment has three parts. Part I asks councils to identify issues and action steps in six categories. This is often done though committees established by the council. Issues are the primary concerns or problems that put children at risk. Discussion in the committee will often

identify several issues and the committee will narrow the list down to the two to three most important issues. Once a council has identified the issues facing þÿ t h e c o u n t y , i t l i s t s c o n c r e t e a c t i o n s t e can accomplish. These actions can be major or minor steps; they can be short or long term. This is the first initiative towards developing a strategic plan for the council. Part II provides an opportunity to make policy recommendations that are forwarded to state agencies and the Legislature. Policy Recommendations are listed that would help the county address the needs of children. This may include specific policy changes for state agencies or specific changes to legislation to: (1) improve the way services are provided, (2) eliminate road blocks or red tape that hinder quality services, or (3) provide for local flexibility in state programs. Part III requires the council to narrow the issues to the top three priority outcomes for children in the county. Once the issues, action steps, and recommendations have been developed for each category the council then identifies the three priorities for the county's children. This is when the council members must identify the most pressing issues. These outcomes should reflect the council priorities for itself, its members, and the community for the next year. þÿ A l l 6 7 C h i Policy Councils listed the top priorities for their council and county in the coming year. These priorities were analyzed based upon the descriptions selected by the county. In analyzing the priorities, weight was given to the higher priorities. Top priorities were given three points, second priorities were given two points, and third priorities were given one point. This was totaled to get the weighted value. Counties were limited to their top three priorities. By limiting the responses to the top three and applying more value to the higher priorities, the most important priorities in the view of the þÿ C h i l d r e n s P o l i c y C o u n c i l s c a n b e s u m m a r

In 2006, substance abuse prevention was the top issue and was clearly the top þÿ p r i o r i t y a m o n g t h e C h i l Family Resource Centers just C o u cracked the top ten issues, but when it came down to the priorities it finished a strong second. Substance abuse prevention was the top priority for 11 counties and Family Resource Centers was the top priority for ten counties.

Prevention Planning Overview

The prevention planning system in Alabama is based on 22 catchment areas. Each catchment area has its own local board (referred to as 310 boards) that is responsible for planning mental health, mental retardation, and substance abuse services for the local catchment area. The funding for each catchment area is determined using a population-based formula. The results of the Alabama Pride Survey, the Alabama Social Indicators of Prevention Need, the Alabama Student Survey of Risk and Protective Factors, the Community Resource Assessment, and þÿ t h e C h i l d r e n s P o l i c y C o u n c i l s N e e d s A s 310 boards for use in the development of their prevention planning efforts.

FY 2008 (INTENDED USE)
FFY 2008 (Intended Use):

The DMH/MR will implement a local needs assessment process for inclusion in the development of department plans including budget requests submitted to the Governor and State Finance Director. Local needs assessment meetings will be held in each 310 Catchment Area to identify needs from the perspective of consumers, family members, advocates, providers and other interested individuals. The identified needs will be organized and forwarded for consideration by regional groups elected from the initial open meetings. Representatives will be elected to represent consumers, family, advocates, providers and others. The regional representatives will prioritize the needs and forward them to the Substance Abuse Coordinating Subcommittee, which will be made up of elected members from the regional representatives, for inclusion in the substance abuse budget request which will be passed on to the Management Steering Committee. The Management Steering Committee will be made up of appointed representatives from statewide substance abuse, mental health and mental retardation organizations. The Management Steering Committee is chaired by the Commissioner of the Alabama Department of Mental Health and Mental Retardation and includes the Associate commissioner for Substance Abuse Services. The Management Steering Committee makes planning and budgetary recommendations to the Commissioner.

In addition to the Local Planning Needs Assessment, the SASD will pursue an update to the previous prevention and treatment needs assessment studies.

PREVENTION:

The prevention needs assessment data, including The Alabama Pride Survey, The þÿ A l a b a m a S o c i a l I n d i c a t o r s o f P r e v e n t i o n Needs Assessment, and the Local Planning Needs Assessment, will be used by each 310 Catchment Area to develop a local needs based plan. The plans will be submitted to the SASD for approval.

TREATMENT:

Treatment related information collected in the Local Planning Needs Assessment will be used in the planning and allocation of resources, particularly to identify areas for initiation of new community resources.

Alabama

Goal #14: Hypodermic Needle Program

GOAL # 14. An agreement to ensure that no program funded through the block grant will use funds to provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs (See 42 U.S.C. 300x-31(a)(1)(F) and 45 C.F.R. 96.135(a)(6)).

FY 2005 (Compliance):

FY 2007 (Progress):

FY 2008 (Intended Use):

FY 2005 (COMPLIANCE)
GOAL #14. The Substance Abuse Services Division will stipulate in contract language that it is prohibited for any contracting program to use Block Grant funds to provide individuals with hypodermic needles or syringes so that such individuals may use illegal drugs.

Objective: Block Grant funds are not used to provide individuals with hypodermic needles or syringes.

FFY 2005 (Compliance):

Result: Accomplished. All contracts issued by the SASD include language prohibiting the dispensing of hypodermic needles or syringes. Compliance with this requirement is monitored by annual site visits to the contracting programs.

FY 2007 (PROGRESS)
FFY 2007 (Progress):

Activity: Reimbursable services will be clearly defined. The purchase of hypodermic needles or syringes will not be identified as a reimbursable service.

Current Status: Accomplished.

FY 2008 (INTENDED)
FFY 2008 (Intended Use):

Activity: Reimbursable services will be clearly defined. The purchase of hypodermic needles or syringes will not be identified as a reimbursable service.

Alabama

Goal #15: Independent Peer Review

GOAL # 15. An agreement to assess and improve, through independent peer review, the quality and appropriateness of treatment services delivered by providers that receive funds from the block grant (See 42 U.S.C. 300x-53(a) and 45 C.F.R. 96.136).

FY 2005 (Compliance):

FY 2007 (Progress):

FY 2008 (Intended Use):

FY 2005 (COMPLIANCE)
Objective: 5% of the contracted programs will participate in the peer review process.

FFY 2005 (Compliance):

Result: Accomplished.

FY 2007 (PROGRESS)
FFY 2007 (Progress):

Activity: Peer reviewers will be accomplished by using professional peers to review the clinical and administrative practices of programs.

Current Status: Peer review will be accomplished by using professional peers to review the clinical and administrative practices of programs. The opportunity for professionals from different programs to discuss best practices is the most advantageous part of the peer review process.

Activity: Reports of the visits will be written and provided to the program receiving the review.

Current Status: Reports of the visits will be written and provided to the program receiving the review and to the Office of Training and Workforce Development. The information will be summarized in a yearly report created by the SASD.

Activity: Records will be kept identifying the reviewer and the program receiving the review.

Current Status: Records will be kept identifying the reviewer and the program receiving the review by the Office of Training and Workforce Development.

FY 2008 (INTENDED)
FFY 2008 (Intended Use):

Activity: Peer reviewers will contact programs to be reviewed and arrange an acceptable date for the review.

Activity: Reports of the visits will be written and provided to the program receiving the review and to the Office of Training and Workforce Development. The information will be summarized in a yearly report created by SASD.

Activity: Records will be kept identifying the reviewer and the program receiving the review by the Office of Training and Workforce Development.

Alabama

Attachment H: Independent Peer Review

Attachment H: Independent Peer Review (See 45 C.F.R. 96.122(f)(3)(v))

In up to three pages provide a description of the State's procedures and activities undertaken to comply with the requirement to conduct independent peer review during FY 2006 (See 42 U.S.C. 300x-53(a)(1) and 45 C.F.R. 96.136).

Examples of procedures may include, but not be limited to:

- the role of the Single State Authority (SSA) for substance abuse prevention activities and treatment services in the development of operational procedures implementing independent peer review;
- the role of the State Medical Director for Substance Abuse Services in the development of such procedures;
- the role of the independent peer reviewers; and
- the role of the entity(ies) reviewed.

Examples of activities may include, but not be limited to:

- the number of entities reviewed during the applicable fiscal year;
- technical assistance made available to the entity(ies) reviewed; and
- technical assistance made available to the reviewers, if applicable.

PURPOSE:
The purpose of the Independent Peer Review is to improve the effectiveness of þÿ A l a b a m a s s u b s t a n c e a b u s e s e r v i c e s . T h i s professional peers to review the clinical and administrative practices of programs by identifying innovations and best clinical practices. As staff from different programs meet, observe, and review program practices, a natural sharing of information will take place. The opportunity for professionals from different programs to discuss best practices is the most advantageous part of the peer review process. This information will be summarized in a yearly report created by the Substance Abuse Services Division of the Department of Mental Health and Mental Retardation.

QUALIFICATIONS OF A PEER REVIEWER:
Peer reviewers shall be individuals with expertise in the field of alcohol and drugs abuse treatment and must be knowledgeable of the various disciplines utilized by the program being reviewed. Peer reviewers must be knowledgeable about the modality being reviewed and its underlying theoretical approach to addiction and must be sensitive to the cultural and environmental issues that may influence the quality of the services provided.

BACKGROUND AND HISTORY OF INDEPENDENT PEER REVIEW:
The Federal Substance Abuse Prevention and Treatment Block Grant Regulations require the State to provide independent peer review. These regulations require that 5% of all programs receiving funding be reviewed annually by professional peers to assess the quality and appropriateness of their treatment services. þÿ Q u a l i t y i s d e f i n e d a s t h e p r o v i s i o n o f constraints of technology, resources, and patient/client circumstances that will meet accepted standards and practices which will improve patient/client health and safety status in the context of recovery. þÿ A p p r o p r i a t e n defined as the provision of treatment services consistent with the patient/client identified clinical needs and level of functioning.

Independent peer reviewers are required to examine: admission criteria/intake process, assessment; treatment planning, including appropriate referral; documentation of treatment services provided; discharge and continuing care planning; and indications of treatment outcomes. The regulations state independent peer reviewers cannot review their own programs or programs which they have administrative oversight and the review must be separate from any funding decisions and not part of any licensing/certification process.

GENERAL OBSERVATIONS:
Independent Peer Reviewers will use a number of methods to gather information on programs and the services they provide. Methods used are:

þÿ "Tours of the facility.
þÿ "Interviews with agency staff performing various functions in the modality reviewing.
þÿ "Review of clinical forms used in the clinical records.
þÿ "Observation of admission/intake processes.
þÿ "Review of client satisfaction surveys or interview clients.
þÿ "Review of open and closed client records.

A clinical review of the program is required by the Federal regulations. The clinical review is broken into six sections:

SECTION 1. Determine if the admission/intake process respects the dignity

of the clients.
SECTION 2. Determine if the assessment process identifies the need for care, the
appropriate level of care and forms the basis for a treatment plan.
SECTION 3. Determine if the treatment plan provides a flexible guide for helping clients get better.
SECTION 4. Determine if the documentation demonstrates the
þÿ d e l i v e r y o f a p p r o p r i a t e t r e a t m e n t s e r v i c
timely manner.
SECTION 5. þÿ D e t e r m i n e i f t h e d i s c h a r g e p l a n s
SECTION 6. þÿ D e t e r m i n e t h e p r o g r a m s p o l i c i e s ,
regarding treatment outcome.
SECTION 7. Determine client satisfaction with the program.
SECTION 8. Administrative Review.
SECTION 9. þÿ R e v i e w e r s S u m m a r y o f P e e r R e v i e
SECTION 10. Providers Assessment of the Independent Per Review Process

REVIEW PROTOCOL:
Each peer reviewer will complete the following:

1. Contact the program to be reviewed to:
   a. Discuss the review agenda and arrange a mutually convenient date. Once the date has been set, the reviewer will inform the SASD and the program being reviewed in writing the date the review is scheduled.
   b. Ask the program being reviewed if there are any specific areas they would like to focus on during the review.
   c. Coordinate with the program being reviewed to have available documentation that will be needed for the review process. Some of this material may be provided to the reviewer prior to the review date. This material may include:

* Agency and or Program brochure,
* Sample case record format to facilitate chart review,
* Schedule of program activities,
* Program mission statement,
* Program objectives and philosophy,
* Criteria for client admission, movement through treatment phases and completion.

2. The review will begin with an introduction during which:
   a. The reviewer explains the purpose of the review and how it will be conducted and asks, again, if there are any areas they would like to focus on during the review.
   b. The program being reviewed provides the reviewer with a general
þÿ o v e r v i e w o f t h e p r o g r a m s o p e r a t i o n s i n c
census.
   c. If possible, the initial meeting should include any staff member who will participate in the review process.

3. A tour of the facility following the introductory session is recommended.
4. The reviewer begins the review process by following the guidelines set
þÿ f o r t h o n t h e I D E P E N D E N T P E E R R E V I E W F O R
how to gather information, focus issues questions, and guidance in completing the final report.
5. Within one week after the site review, the reviewer will provide a draft of the report to the program reviewed.
6. The program may respond, verbally or in writing, to the reviewer to determine the information included in the final report.

7. Within 30 calendar days of the program review, the reviewer will be complete the final report and send it to the office listed below along with a contract/field voucher.

Alabama

Goal #16: Disclosure of Patient Records

GOAL # 16. An agreement to ensure that the State has in effect a system to protect patient records from inappropriate disclosure (See 42 U.S.C. 300x-53(b), 45 C.F.R. 96.132(e), and 42 C.F.R. Part 2).

FY 2005 (Compliance):

FY 2007 (Progress):

FY 2008 (Intended Use):

FY 2005 (COMPLIANCE)
FFY 2005 (Compliance):

Result: Accomplished. Standards relating to the provision of confidentiality of client records were enforced for every substance abuse treatment program certified by the SASD. Training was also provided pertaining to the provision of confidentiality for substance abuse clients.
State Goals.

FY 2007 (PROGRESS)
FFY 2007 (Progress):

Activity: The Substance Abuse Services Division will promulgate standards to include a client rights section, which covers confidentiality.

Current Status: Accomplished.

Activity: All substance abuse providers in Alabama will be reviewed in accordance with the certification standards.

Current Status: Accomplished.

Activity: Any program found non-compliant with any standard, including the client rights portion, will be given opportunity for correction. If corrective action is not taken the program will not be certified, therefore, cannot operate in the state of Alabama.

Current Status: On-going.

Activity: Training will be provided regarding client rights as related to disclosure of patient records.

Current Status: On-going.

FY 2008 (INTENDED)
FFY 2008 (Intended Use):

Activity: The Substance Abuse Services Division will promulgate standards to include a client rights section that covers confidentiality.

Activity: All substance abuse providers in Alabama will be reviewed in accordance with the certification standards.

Activity: Any program found non-compliant with any standard, including the client rights portion, will be given opportunity for correction. If corrective action is not taken the program will not be certified, therefore, cannot operate in the state of Alabama.

Activity: Training will be provided regarding client rights as related to disclosure of patient records.

Alabama

Goal #17: Charitable Choice

GOAL # 17. An agreement to ensure that the State has in effect a system to comply with 42 U.S.C. 300x-65 and 42 C.F.R. part 54 (See 42 C.F.R. 54.8(b) and 54.8(c)(4), Charitable Choice Provisions and Regulations).

FY 2005 (Compliance):

FY 2007 (Progress):

FY 2008 (Intended Use):

Under Charitable Choice, States, local governments, and religious organizations, each as SAMHSA grant recipients, must: (1) ensure that religious organizations that are providers provide notice of their right to alternative services to all potential and actual program beneficiaries (services recipients); (2) ensure that religious organizations that are providers refer program beneficiaries to alternative services; and (3) fund and/or provide alternative services. The term “alternative services” means services determined by the State to be accessible and comparable and provided within a reasonable period of time from another substance abuse provider (“alternative provider”) to which the program beneficiary (“services recipient”) has no religious objection.

The purpose of Attachment I is to document how your State is complying with these provisions.

Page 140 of 240

FY 2005 (COMPLIANCE)
FFY 2005 (Compliance): The Substance Abuse Services Division (SASD) will assure that contracting religious organizations provide clients: (1) notice of their right to alternative services; (2) give clients options to choose alternative services; and (3) provide alternative services if requested by clients.

FY 2007 (PROGRESS)
FY 2007 (Progress): The SASD requires through a signed agreement with
þÿ f a i t h - b a s e d c o n t r a c t i n g o r g a n i z a t i o n s t h
þÿ g r o u p d e v o t i o n s a n d a n y o t h e r a c t i v i t i e s

FY 2008 (INTENDED)
FY 2008 (Intended Use): The SASD will require Faith-Based organizations to sign an annual statement agreeing to the requirements of the Charitable Choice Provisions and Regulations.

State:
Alabama

Attachment I

Under Charitable Choice, States, local governments, and religious organizations, each as SAMHSA grant recipients, must: (1) ensure that religious organizations that are providers provide notice of their right to alternative services to all potential and actual program beneficiaries (services recipients); (2) ensure that religious organizations that are providers refer program beneficiaries to alternative services; and (3) fund and/or provide alternative services. The term “alternative services” means services determined by the State to be accessible and comparable and provided within a reasonable period of time from another substance abuse provider (“alternative provider”) to which the program beneficiary (“services recipient”) has no religious objection.

The purpose of Attachment I is to document how your State is complying with these provisions.

Attachment I - Charitable Choice

For the fiscal year prior (FY 2007) to the fiscal year for which the State is applying for funds provide a description of the State’s procedures and activities undertaken to comply with the provisions.

Notice to Program Beneficiaries - Check all that apply:

- ☒ Use model notice provided in final regulations.
- ☒ Use notice developed by State (attached copy).
- ☒ State has disseminated notice to religious organizations that are providers.
- ☒ State requires these religious organizations to give notice to all potential beneficiaries.

Referrals to Alternative Services - Check all that apply:

- ☐ State has developed specific referral system for this requirement.
- ☒ State has incorporated this requirement into existing referral system(s).
- ☐ SAMHSA’s Treatment Facility Locator is used to help identify providers.
- ☐ Other networks and information systems are used to help identify providers.
- ☐ State maintains record of referrals made by religious organizations that are providers.
- ☐ 0 Enter total number of referrals necessitated by religious objection to other substance abuse providers ('alternative providers'), as define above, made in previous fiscal year. Provide total ONLY; no information on specific referrals required.

Brief description (one paragraph) of any training for local governments and faith-based and community organizations on these requirements.

The Substance Abuse Services Division (SASD) will assure that contracting religious organizations provide clients: (1) notice of their right to alternative services; (2) give clients options to choose alternative services; and (3) provide alternative services if requested by clients.

FY 2007 (Progress): The SASD requires through a signed agreement with faith-based contracting organizations that "Participation in worship services, group devotions and any other activities will be optional."

FY 2008 (Intended Use): The SASD will require Faith-Based organizations to sign an annual statement agreeing to the requirements of the Charitable Choice Provisions and Regulations.

State:
Alabama

Attachment J

If your State plans to apply for any of the following waivers, check the appropriate box and submit the request for a waiver at the earliest possible date.

- ☐ To expend not less than an amount equal to the amount expended by the State for FY 1994 to establish new programs or expand the capacity of existing programs to make available treatment services designed for pregnant women and women with dependent children (See 42 U.S.C. 300x-22(b)(2) and 45 C.F.R. 96.124(d))

- ☐ Rural area early intervention services HIV requirements (See 42 U.S.C. 300x-24(b)(5)(B) and 45 C.F.R. 96.128(d))

- ☐ Improvement of process for appropriate referrals for treatment, continuing education, or coordination of various activities and services (See 42 U.S.C. 300x-28(d) and 45 C.F.R. 96.132(d))

- ☐ Statewide maintenance of effort (MOE) expenditure levels (See 42 U.S.C. 300x-30(c) and 45 C.F.R. 96.134(b))

- ☐ Construction/rehabilitation (See 42 U.S.C. 300x-31(c) and 45 C.F.R. 96.135(d))

If your State proposes to request a waiver at this time for one or more of the above provisions, include the waiver request as an attachment to the application, if possible. The Interim Final Rule, 45 C.F.R. 96.124(d), 96.128(d), 96.132(d), 96.134(b), and 96.135(d), contains information regarding the criteria for each waiver, respectively. A formal waiver request must be submitted to SAMHSA at some point in time if not included as an attachment to the application.

Alabama

Attachment J: Waivers

Attachment J: Waivers

If your State proposes to request a waiver at this time for one or more of the above provisions, include the waiver request as an attachment to the application, if possible. The Interim Final Rule, 45 C.F.R. 96.124(d), 96.128(d), 96.132(d), 96.134(b), and 96.135(d), contains information regarding the criteria for each waiver, respectively. A formal waiver request must be submitted to SAMHSA at some point in time if not included as an attachment to the application.

SUBSTANCE ABUSE STATE AGENCY SPENDING REPORT

State:
Alabama

Dates of State Expenditure Period:
From 10/1/2004 to 9/30/2005

Activity	A. SAPT Block Grant FY 2005 Award (Spent)	B. Medicaid (Federal, State and Local)	C. Other Federal Funds (e.g., Medicare, other public welfare)	D. State Funds	E. Local Funds (excluding local Medicaid)	F. Other
1. Substance Abuse Prevention* and Treatment	$16,810,026	$2,769,551	$	$6,691,266	$	$
2. Primary Prevention	$4,811,204		$	$	$	$
3. Tuberculosis Services	$	$	$	$	$	$
4. HIV Early Intervention Services	$1,185,861	$	$	$	$	$
5. Administration (excluding program/provider level)	$1,200,373		$	$324,640	$	$
6. Column Total	$24,007,464	$2,769,551	$	$7,015,906	$	$

*** Prevention other than Primary Prevention**

Form 4ab

State:
Alabama

Form 4a. Primary Prevention Expenditures Checklist

	Block Grant FY 2005	Other Federal	State	Local	Other
Information Dissemination	**$384,896**	**$**	**$**	**$**	**$**
Education	**$2,944,750**	**$**	**$**	**$**	**$**
Alternatives	**$769,793**	**$**	**$**	**$**	**$**
Problem Identification & Referral	**$43,008**	**$**	**$**	**$**	**$**
Community-Based Process	**$76,979**	**$**	**$**	**$**	**$**
Environmental	**$317,539**	**$**	**$**	**$**	**$**
Other	**$274,239**	**$**	**$**	**$**	**$**
Section 1926 - Tobacco	**$**	**$**	**$**	**$**	**$**
TOTAL	**$4,811,204**	**$**	**$**	**$**	**$**

Form 4b. Primary Prevention Expenditures Checklist

	Block Grant FY 2005	Other Federal	State	Local	Other
Universal Indirect	**$**	**$**	**$**	**$**	**$**
Universal Direct	**$**	**$**	**$**	**$**	**$**
Selective	**$**	**$**	**$**	**$**	**$**
Indicated	**$**	**$**	**$**	**$**	**$**
TOTAL	**$**	**$**	**$**	**$**	**$**

Form 4c

Resource Development Expenditure Checklist

State:
Alabama

Did your State fund resource development activities from the FY 2005 block grant?

☐ Yes ☒ No

	Column 1 Treatment	Column 2 Prevention	Column 3 Additional Combined	Total
Planning, Coordination and Needs Assessment	**$**	**$**	**$**	**$**
Quality Assurance	**$**	**$**	**$**	**$**
Training (post-employment)	**$**	**$**	**$**	**$**
Education (pre-employment)	**$**	**$**	**$**	**$**
Program Development	**$**	**$**	**$**	**$**
Research and Evaluation	**$**	**$**	**$**	**$**
Information Systems	**$**	**$**	**$**	**$**
TOTAL	**$**	**$**	**$**	**$**

Expenditures on Resource Development Activities are:

☒ **Actual** ☐ **Estimated**

SUBSTANCE ABUSE ENTITY INVENTORY

State:
Alabama

					FISCAL YEAR 2005			
1. Entity Number	2. National Register (I-SATS) ID (Mark [X] box if no ID)	3. Area Served	4. State Funds (Spent during State Expenditure Period)		5. SAPT Block Grand Funds for Substance Abuse Prevention (other than primary prevention) and Treatment Services	5.a. SAPT Block Grant Funds for Services for Pregnant Women and Women with Dependent Children	6. SAPT Block Grant Funds for Primary Prevention	7. SAPT Block Grant Funds for Early Intervention Services for HIV (if applicable)
0001	AL750405	Statewide (optional)	$211,354		$1,329,850	$828,638	$132,720	$329,123
0002	AL300037	Statewide (optional)	$200,033		$673,702	$330,004	$121,683	$
0004	AL	Statewide (optional)	$		$293,090	$	$	$
0005	AL900547	Region 2	$2,000		$	$	$278,716	$
0006	AL750561	Region 4	$76,864		$221,844	$	$110,700	$
0007	AL900091	Region 2	$39,993		$653,964	$111,541	$198,367	$
0008	AL302108	Region 3	$42,857		$411,350	$158,000	$93,363	$113,301
0009	AL900109	Region 2	$394		$269,532	$	$	$
0010	AL900604	Region 3	$832,639		$1,077,433	$	$	$101,807
0011	AL750157	Statewide (optional)	$39,600		$235,840	$	$	$
0012	AL900570	Region 1	$14,684		$137,438	$	$251,590	$
0013	AL750272	Statewide (optional)	$2,000		$	$	$554,924	$

OMB No. 0930-0080 Approved: 09/30/2007 Expires: 09/30/2010

State:
Alabama

					FISCAL YEAR 2005			
1. Entity Number	2. National Register (I-SATS) ID (Mark [X] box if no ID)	3. Area Served	4. State Funds (Spent during State Expenditure Period)		5. SAPT Block Grand Funds for Substance Abuse Prevention (other than primary prevention) and Treatment Services	5.a. SAPT Block Grant Funds for Services for Pregnant Women and Women with Dependent Children	6. SAPT Block Grant Funds for Primary Prevention	7. SAPT Block Grant Funds for Early Intervention Services for HIV (if applicable)
0014	AL900620	Region 2	$138,886		$604,591	$	$21,450	$52,188
0015	AL900554	Statewide (optional)	$17,047		$164,250	$	$	$
0016	AL750090	Region 2	$50,909		$228,545	$	$140,970	$
0017	AL901362	Region 4	$62,848		$1,120,891	$	$	$
0018	AL100551	Region 1	$3,500		$	$	$518,285	$
0019	AL900612	Region 3	$13,922		$562,291	$134,839	$238,140	$
0020	AL302371	Region 3	$15,383		$88,560	$	$30,360	$5,859
0021	AL100106	Region 2	$		$	$	$123,446	$
0022	AL750058	Region 2	$254,907		$115,673	$	$	$
0023	AL100502	Region 4	$		$	$	$53,506	$
0024	AL750074	Region 2	$		$60,913	$	$87,833	$
0025	AL900737	Region 1	$94,547		$484,294	$	$245,400	$12,575

OMB No. 0930-0080 Approved: 09/30/2007 Expires: 09/30/2010

State:
Alabama

					FISCAL YEAR 2005			
1. Entity Number	2. National Register (I-SATS) ID (Mark [X] box if no ID)	3. Area Served	4. State Funds (Spent during State Expenditure Period)		5. SAPT Block Grand Funds for Substance Abuse Prevention (other than primary prevention) and Treatment Services	5.a. SAPT Block Grant Funds for Services for Pregnant Women and Women with Dependent Children	6. SAPT Block Grant Funds for Primary Prevention	7. SAPT Block Grant Funds for Early Intervention Services for HIV (if applicable)
0026	AL301407	Region 3	$93,593		$552,835	$134,964	$65,620	$101,137
0027	AL900588	Region 3	$		$268,812	$	$	$
0028	AL900786	Region 1	$102,660		$847,439	$	$153,599	$
0029	AL901206	Region 4	$		$557,499	$119,231	$	$218,675
0030	AL100429	Region 2	$50,743		$54,539	$	$91,442	$
0031	AL750512	Region 1	$		$	$	$54,117	$
0032	AL900117	Region 1	$38,703		$514,874	$209,507	$92,720	$
0033	AL750199	Region 2	$524,691		$280,898	$	$178,364	$
0034	AL900653	Region 1	$		$193,529	$	$	$
0035	AL750371	Region 2	$		$483,310	$	$	$
0036	AL900778	Region 1	$34,408		$776,933	$184,500	$174,380	$
0037	AL750140	Region 4	$53,658		$639,056	$	$120,565	$

State:
Alabama

					FISCAL YEAR 2005			
1. Entity Number	2. National Register (I-SATS) ID (Mark [X] box if no ID)	3. Area Served	4. State Funds (Spent during State Expenditure Period)		5. SAPT Block Grand Funds for Substance Abuse Prevention (other than primary prevention) and Treatment Services	5.a. SAPT Block Grant Funds for Services for Pregnant Women and Women with Dependent Children	6. SAPT Block Grant Funds for Primary Prevention	7. SAPT Block Grant Funds for Early Intervention Services for HIV (if applicable)
0038	AL900513	Region 4	$21,297		$327,845	$101,788	$102,660	$
0039	AL750082	Region 2	$		$90,135	$	$	$
0040	AL302330	Region 1	$2,014,647		$222,954	$	$150,444	$
0041	AL100049	Region 2	$97,043		$660,061	$143,753	$160,073	$251,196
0042	AL900687	Region 3	$3,500		$55,537	$	$41,760	$
0043	AL750124	Region 4	$84,123		$1,087,907	$	$224,007	$
0044	AL100668	Region 1	$120,596		$311,904	$99,640	$	$
0051	X	Statewide (optional)	$30,057		$	$	$	$
0053	X	Statewide (optional)	$324,640		$	$	$	$
0056	X	Statewide (optional)	$43,537		$	$	$	$
0057	X	Region 3	$775,000		$	$	$	$
0058	X	Region 2	$75,000		$	$	$	$

OMB No. 0930-0080 Approved: 09/30/2007 Expires: 09/30/2010

State:
Alabama

					FISCAL YEAR 2005			
1. Entity Number	2. National Register (I-SATS) ID (Mark [X] box if no ID)	3. Area Served	4. State Funds (Spent during State Expenditure Period)		5. SAPT Block Grand Funds for Substance Abuse Prevention (other than primary prevention) and Treatment Services	5.a. SAPT Block Grant Funds for Services for Pregnant Women and Women with Dependent Children	6. SAPT Block Grant Funds for Primary Prevention	7. SAPT Block Grant Funds for Early Intervention Services for HIV (if applicable)
0059	X	Region 2	$		$22,135	$	$	$
0061	X	Statewide (optional)	$20,075		$	$	$	$
0062	X	Region 3	$1,500		$	$	$	$
0063	X	Region 3	$45,511		$	$	$	$
0064	X	Region 3	$50,000		$	$	$	$
0065	X	Region 3	$70,000		$	$	$	$
00SC	X	Region 4	$173,057		$932	$	$	$
0101	X	Region 1	$		$37,849	$	$	$
0ABC	X	Statewide (optional)	$50,000		$	$	$	$
cmha	X	Region 1	$3,500		$88,991	$	$	$
TOTAL			$7,015,906		$16,810,025	$2,556,405	$4,811,204	$1,185,861

OMB No. 0930-0080 Approved: 09/30/2007 Expires: 09/30/2010

PROVIDER ADDRESS TABLE

State:
Alabama

Provider ID	Description	Provider Address
0051	Department of Public Health	P. O. Box 303017, Montgomery, AL, 36130-3017,
0053	ADMINISTRATION	P. O. Box 301410, Montgomery, AL, 36130, 334-242-3961,
0056	AL School	Alabama School of Alcohol and other Drug Studies, 300 Dexter Ave., Montgomery, AL, 36104,
0057	Human Resource Develpment Institute (HRDI)	411 Wall Street, Suite B., Montgomery, AL, 36106,
0058	Rapha Ministries	677 W. Covington Ave., Attalla, AL, 35954,
0059	Hope House	1002 2nd Avenue East, Oneonta, AL, 35121,
0061	SE School	Conference of Alcohol and other Drug Programs, Inc., 312 Ashbrook Lane, Athens, GA, 30605,
0062	Montgomery Mental Health Authority	101 Coliseum Blvd., Montgomery, AL, 36109,
0063	Harmony Information Systems	12120 Sunset Hills Road, Suite 500, Reston, VA, 20190,
0064	Alabama Department of Education	50 North Ripley Street, Montgomery, AL, 36104,
0065	Family Guidance Center	2358 Fairlane Drive, Montgomery, AL, 36116,
00SC	Second Choice	552 Holcombe Avenue, Mobile, AL, 36606,
0101	Recovery Services	P. O. Box 680693, Fort Payne, AL, 35968,
0ABC	ALABAMA ABC BOARD	2715 Gunter Park Drive, West, Montgomery, AL, 36109,
cmha	Cullman Mental Health Authority	1909 Commerce Avenue North West, Cullman, AL, 35055,

Prevention Strategy Report

State:
Alabama

Column A (Risks)	Column B (Strategies)	Column C (Providers)
Children of Substance Abusers [1]	Clearinghouse/information resources centers [1]	0
	Resources directories [2]	0
	Brochures [4]	0
	Speaking engagements [6]	0
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	0
	Parenting and family management [11]	0
	Ongoing classroom and/or small group sessions [12]	0
	Peer leader/helper programs [13]	0
	Education programs for youth groups [14]	0
	Mentors [15]	0
	Preschool ATOD prevention programs [16]	0
	Drug free dances and parties [21]	0
	Youth/adult leadership activities [22]	0
	Community drop-in centers [23]	0
	Community service activities [24]	0
	Recreation activities [26]	0
	Student Assistance Programs [32]	0
	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41]	0
	Multi-agency coordination and collaboration/coalition [43]	0
	Community team-building [44]	0
	Promoting the establishment of review of alcohol, tobacco, and drug use policies in schools [51]	0
	Guidance and technical assistance on monitoring enforcement governing availability and distribution of alcohol, tobacco, and other drug use [52]	0

Form 6a: Risk - Strategies (...continued)

State:
Alabama

Column A (Risks)	Column B (Strategies)	Column C (Providers)
(cont...) Children of Substance Abusers [1]	Modifying alcohol and tobacco advertising pratices [53]	0
	Product pricing strategies [54]	0
Pregnant Women/Teens [2]	Clearinghouse/information resources centers [1]	0
	Resources directories [2]	0
	Brochures [4]	0
	Speaking engagements [6]	0
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	0
	Parenting and family management [11]	0
	Ongoing classroom and/or small group sessions [12]	0
	Peer leader/helper programs [13]	0
	Education programs for youth groups [14]	0
	Preschool ATOD prevention programs [16]	0
	Drug free dances and parties [21]	0
	Youth/adult leadership activities [22]	0
	Community service activities [24]	0
	Recreation activities [26]	0
	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41]	0
	Multi-agency coordination and collaboration/coalition [43]	0
	Community team-building [44]	0
Drop-Outs [3]	Parenting and family management [11]	0
	Peer leader/helper programs [13]	0
	Youth/adult leadership activities [22]	0

Form 6a: Risk - Strategies (...continued)

State:
Alabama

Column A (Risks)	Column B (Strategies)	Column C (Providers)
(cont...) Drop-Outs [3]	Multi-agency coordination and collaboration/coalition [43]	0
	Community team-building [44]	0
Violent and Delinquent Behavior [4]	Clearinghouse/information resources centers [1]	0
	Brochures [4]	0
	Speaking engagements [6]	0
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	0
	Parenting and family management [11]	0
	Ongoing classroom and/or small group sessions [12]	0
	Education programs for youth groups [14]	0
	Student Assistance Programs [32]	0
	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41]	0
	Multi-agency coordination and collaboration/coalition [43]	0
	Community team-building [44]	0
Economically Disadvantaged [6]	Clearinghouse/information resources centers [1]	0
	Resources directories [2]	0
	Brochures [4]	0
	Radio and TV public service announcements [5]	0
	Speaking engagements [6]	0
	Health fairs and other health promotion, e.g., conferences, meetings, seminars [7]	0
	Parenting and family management [11]	0
	Ongoing classroom and/or small group sessions [12]	0
	Peer leader/helper programs [13]	0

Form 6a: Risk - Strategies (...continued)

State:
Alabama

Column A (Risks)	Column B (Strategies)	Column C (Providers)
(cont...) Economically Disadvantaged [6]	Education programs for youth groups [14]	0
	Preschool ATOD prevention programs [16]	0
	Drug free dances and parties [21]	0
	Youth/adult leadership activities [22]	0
	Community service activities [24]	0
	Recreation activities [26]	0
	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41]	0
	Systematic planning [42]	0
	Multi-agency coordination and collaboration/coalition [43]	0
	Community team-building [44]	0
	Promoting the establishment of review of alcohol, tobacco, and drug use policies in schools [51]	0
	Guidance and technical assistance on monitoring enforcement governing availability and distribution of alcohol, tobacco, and other drug use [52]	0
	Modifying alcohol and tobacco advertising pratices [53]	0
	Product pricing strategies [54]	0
Abuse Victims [8]	Parenting and family management [11]	0
	Ongoing classroom and/or small group sessions [12]	0
	Education programs for youth groups [14]	0
	Preschool ATOD prevention programs [16]	0
	Community and volunteer training, e.g., neighborhood action training, impactor training, staff/officials training [41]	0
	Systematic planning [42]	0
	Multi-agency coordination and collaboration/coalition [43]	0
	Community team-building [44]	0

Form 6a: Risk - Strategies (...continued)

State:
Alabama

Column A (Risks)	Column B (Strategies)	Column C (Providers)
Already Using Substances [9]	Parenting and family management [11]	0
	Peer leader/helper programs [13]	0
	Education programs for youth groups [14]	0
	Youth/adult leadership activities [22]	0
	Student Assistance Programs [32]	0

TREATMENT UTILIZATION MATRIX

State:
Alabama

Dates of State Expenditure Period:
From 10/1/2004 to 9/30/2005 (Same as Form 1)

			Costs Per Person		
Level of Care	**A. Number of Admissions**	**B. Number of Persons Served**	**C. Mean Cost of Services**	**D. Median Cost of Services**	**E. Standard Deviation of Cost**
Detoxification (24 hour Care)					
1. Hospital Inpatient			**$.00**	**$.00**	**$.00**
2. Free-standing Residential	**984**	**797**	**$606.92**	**$.00**	**$.00**
Rehabilitation / Residential					
3. Hospital Inpatient			**$.00**	**$.00**	**$.00**
4. Short-term (up to 30 days)	**4,010**	**3,721**	**$1,167.78**	**$.00**	**$.00**
5. Long-term (over 30 days)	**1,721**	**1,666**	**$3,053.92**	**$.00**	**$.00**
Ambulatory (Outpatient)					
6. Outpatient			**$.00**	**$.00**	**$.00**
7. Intensive Outpatient	**30,915**	**25,743**	**$568.01**	**$.00**	**$.00**
8. Detoxification			**$.00**	**$.00**	**$.00**
9. Opioid Replacement Therapy	**545**	**509**	**$975.93**	**$.00**	**$.00**

Form 7b

Number Of Persons Served (Unduplicated Count) For Alcohol And Other Drug Use In State-Funded Services By Age, Sex, And Race/Ethnicity

State:
Alabama

AGE GROUP	A. TOTAL	B. White		C. Black or African American		D. Native Hawaiian / Other Pacific Islander		E. Asian		F. American Indian / Alaska Native		G. More than one race reported		H. Unknown		I. Not Hispanic or Latino		J. Hispanic or Latino	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
1. 17 and under	1,821	665	319	670	134	1			2	4	1	10	7	6	2	1,336	457	20	8
2. 18-24	5,641	2,287	1,214	1,698	367	3	2	5	4	10	10	13	7	17	4	3,979	1,591	54	14
3. 25-44	15,591	5,563	3,742	4,645	1,474		1	17	7	32	16	30	13	39	12	10,191	5,209	135	45
4. 45-64	5,581	1,938	836	2,150	605		1	5	3	12	9	5	3	10	4	4,093	1,448	27	13
5. 65 and over	134	69	9	48	7						1					116	17	1	
6. Total	28,768	10,522	6,120	9,211	2,587	4	4	27	16	58	37	58	30	72	22	19,715	8,722	237	80
7. Pregnant Women	289		198		83		1				4		1		2		284		4

Did the values reported by your State on Forms 7a and 7b come from a client-based system(s) with unique client identifiers?

☒ **Yes** ☐ **No**

Numbers of Persons Served who were admitted in a period prior to the 12 month reporting period: 3,854

Alabama

Description of Calculations

Description of Calculations

If revisions or changes are necessary to prior years' description of the following, please provide: a brief narrative describing the amounts and methods used to calculate the following: (a) the base for services to pregnant women and women with dependent children as required by 42 U.S.C. 300x-22(b)(1); and, for 1994 and subsequent fiscal years report the Federal and State expenditures for such services; (b) the base and Maintenance of Effort (MOE) for tuberculosis services as required by 42 U.S.C. 300x-24(d); and, (c) for designated States, the base and MOE for HIV early intervention services as required by 42 U.S.C. 300x-24(d) (See 45 C.F.R. 96.122(f)(5)(ii)(A)(B)(C)).

A) Pregnant Women and Women with Dependent Children

The base for services to pregnant women and women with dependent children was established in 1992 at $92,200. Aletheia House, Inc., NFR ID # AL 300037, had expensed $92,200.00. As per Section 1922 of the Block Grant five percent of the FFY 1993 grant was identified for services to pregnant women and women with dependent children. The FFY 1993 grant amount was $12,398,438 X .05 = $619,921.90. Adding $92,200 plus $619,921.90= $712,121.90 set-aside for FFY 1993. The FFY 1994 grant amount was $13,083,374.00 X .05 = $654,168.70. Adding $712,121.90 from FFY 1993 and $654,168.70 from FFY 1994 yielded a maintenance of effort of $1,366,290.60 for FFY 1994 and subsequent fiscal years.

Expenditures:

SFY 1994	1,366,290.60		
SFY 1995	1,366,290.60		
SFY 1996	1,366,290.60		
SFY 1997	1,366,290.60		
SFY 1998	1,366,290.60		
SFY 1999	1,492,212.00		
SFY 2000	1,366,290.60		
SFY 2001	2,465,841.00		
	SFY 2002		2,302,085.00
SFY 2003	2,405,684.18		
SFY 2004	2,843,124.00		
	SFY 2005		2,626,405.00
	SFY 2006		2,556,405.00

B) Tuberculosis

The Alabama Department of Public Health is responsible for monitoring the trends in the tuberculosis rate and administering tuberculosis services in Alabama. When it became a necessity to establish a M.O.E. base for tuberculosis services provided to substance abuse clients, the SASD coordinated with the Alabama Department of Public Health as described in Appendix A. There were no funds spent for tuberculosis services at the contracting substance abuse programs. The Department of Public Health estimated that 6% of the citizens they provided tuberculosis services to were substance abusing. Therefore, a M.O.E. base was established by multiplying the Department of Public Health¿s budget (100% state funding) by the estimated 6% for SFY 1991 and SFY 1992, yielding a M.O.E. base of $148,200.

As the SASD and the Department of Public Health progressed through the process of testing every client entering substance abuse treatment, it was discovered (as described in Appendix A) that the complete testing was not cost effective. The process was modified to allow for testing of those clients that are observed at admission to be symptomatic for tuberculosis.

This summary (Appendix A) has been submitted as part of each block grant application since the change October 1, 1995.

C) HIV

Alabama became a HIV designated state in 1995. At that time there were no funds being spent for HIV services for substance abuse treatment clients. Therefore, the M.O.E. for HIV has always been reported as zero.

Alabama has, since 1995, set-aside 5% of each block grant award for HIV Early Intervention Services.

FFY 1995 $16,533,558 X.05 = $ 826.677.90

FFY 1996	17,021,620	X.05	=	851,081.00
FFY 1997	18,766,069	X.05	=	974,542.45*
FFY 1998	18,766,069	X.05	=	974,542.45*
FFY 1999	21,666,850	X.05	=	1,083,342.00
FFY 2000	22,197,312	X.05	=	1,109,865.60
FFY 2001	22,994,659	X.05	=	1,149,732.95
FFY 2002	23,828,000	X.05	=	1,191,400.00
FFY 2003	23,970,196	X.05	=	1,249,858.00
FFY 2004	24,056,022	X.05	=	1,039,630.00 **
FFY 2005	24,056,022	x.05	=	1,113,265.00 **
FFY 2006	24,007,464	x.05	=	1,200,373.20 **

The SASD has assured that these funds are expended for HIV Early Intervention Services through the contracting system, data reporting system and monitoring.

* Included $36,239 from the SSI/SSDI supplemental appropriation.
** Alabama was not a designated state but continued to spend BG funds for HIV Early Intervention Services.

State:
Alabama

SSA (MOE Table I)

Total Single State Agency (SSA) Expenditures for Substance Abuse (Table I)

PERIOD (A)	EXPENDITURES (B)	B1(2005) + B2(2006) / 2 (C)
SFY 2005 (1)	$7,581,387	
SFY 2006 (2)	$9,256,299	$8,418,843
SFY 2007 (3)	$9,147,589	

Are the expenditure amounts reported in Columns B "actual" expenditures for the State fiscal years involved?

FY 2005 ☒ **Yes** ☐ **No**

FY 2006 ☒ **Yes** ☐ **No**

FY 2007 ☒ **Yes** ☐ **No**

If estimated expenditures are provided, please indicate when "actual" expenditure data will be submitted to SAMHSA(mm/dd/yyyy): 1/30/2008

The MOE for State fiscal year(SFY) 2007 is met if the amount in Box B3 is greater than or equal to the amount in Box C2 assuming the State complied with MOE requirements in these previous years.

The State may request an exclusion of certain non-recurring expenditures for a singular purpose from the calculation of the MOE, provided it meets CSAT approval based on review of the following information:

Did the State have any non-recurring expenditures for a specific purpose which were not included in the MOE calculation?

☐ **Yes** ☒ **No** **If yes, specify the amount and the State fiscal year:** $0 | 0

Did the State include these funds in previous year MOE calculations? ☐ **Yes** ☒ **No**

When did the State submit a request to the SAMHSA Administration to exclude these funds from the MOE calculations(Date)?

SSA (MOE Table I) Footnotes
It has been determined that the State Expenditure total for 2005 was incorrectly reported. Total State Expenditures of $5,929,011 were reported. The correct Total State Expenditure for 2005 is $7,581,387. Changing this amount also changed the M.O.E. for 2006 from $5,942,531 to $6,768,719.

TB (MOE Table II)

State:
Alabama

Statewide Non-Federal Expenditures for Tuberculosis Services to Substance Abusers in Treatment (Table II)

(BASE TABLE)

PERIOD	Total of All State Funds Spent on TB Services (A)	% of TB Expenditures Spent on Clients who were Substance Abusers in Treatment (B)	Total State Funds Spent on Clients who were Substance Abusers in Treatment (A x B) (C)	Average of Columns C1 and C2 C1 + C2 / 2 MOE BASE (D)
SFY 1991 (1)	$2,470,000	6%	$148,200	
SFY 1992 (2)	$2,470,000	6%	$148,200	$148,200

(MAINTENANCE TABLE)

PERIOD	Total of All State Funds Spent on TB Services (A)	% of TB Expenditures Spent on Clients who were Substance Abusers in Treatment (B)	Total State Funds Spent on Clients who were Substance Abusers in Treatment (A x B)
SFY 2007 (3)	$2,873,796	6%	$172,428

HIV (MOE Table III)

State:
Alabama

Statewide Non-Federal Expenditures for HIV Early Intervention Services to Substance Abusers in Treatment (Table III)

(BASE TABLE)

PERIOD	Total of All State Funds Spent on Early Intervention Services for HIV* (A)	Average of Columns A1 and A2 A1 + A2 / 2 MOE BASE (B)
SFY1992 (1)	$0	
SFY1993 (2)	$0	$0

(MAINTENANCE TABLE)

PERIOD	Total of All State Funds Spent on Early Intervention Services for HIV* (A)
SFY 2007 (3)	$0

*** Provided to substance abusers at the site at which they receive substance abuse treatment**

Womens (MOE TABLE IV)

State:
Alabama

Expenditures for Services to Pregnant Women and Women with Dependent Children (Table IV)

(MAINTENANCE TABLE)

PERIOD	Total Women's BASE (A)	Total Expenditures (B)
1994	$1,366,290	
2005		$2,406,841
2006		$2,626,405
2007		$2,556,405

Enter the amount the State plans to expend in FY 2008 for services for pregnant women and women with dependent children (amount entered must be not less than amount entered in Table IV Maintenance - Box A {1994}): $2,556,405

Alabama

1. Planning

1. Planning

This item addresses compliance of the State's planning procedures with several statutory requirements. It requires completion of narratives and a checklist.

These are the statutory requirements:

- 42 U.S.C. 300x-29, 45 C.F. R. 96.133 and 45 C.F.R. 96.122(g)(13) require the State to submit a Statewide assessment of need for both treatment and prevention.

In a narrative of up to three pages, describe how your State carries out sub-State area planning and determines which areas have the highest incidence, prevalence, and greatest need. Include a definition of your State's sub-State planning areas. Identify what data is collected, how it is collected, and how it is used in making these decisions. If there is a State, regional, or local advisory council, describe their composition and their role in the planning process. Describe the monitoring process the State will use to assure that funded programs serve communities with the highest prevalence and need. Those States that have a State Epidemiological Workgroup or a State Epidemiological Outcomes Workgroup, must describe its composition and its contribution to needs assessment, planning, and evaluation processes for primary prevention and treatment planning. States are encouraged to utilize the epidemiological analyses and profiles to establish substance abuse prevention and treatment goals at the State level.

- 42 U.S.C. 300x-51 and 45 C.F. R. 96.123(a)(13) require the State to make the State plan public in such a manner as to facilitate public comment from any person during the development of the plan.

In a narrative of up to two pages, describe the process your State used to facilitate public comment in developing the State's plan and its FY 2008 application for SAPT Block Grant funds.

PLANNING

1. Provide an adequate narrative description of how the State carried out substate area planning and determined which areas have the highest prevalence and greatest need.

Treatment Needs Assessment and Planning

The Substance Abuse Services Division was awarded a needs assessment CSAT grant beginning October 1, 1993. All studies have been completed. The combined Treatment Needs Assessment Studies (Social Indicators, Telephone Household Survey, Data Linkage and Actuarial) were all used to assist the SASD with substate planning. The 'family' of Treatment Needs Assessment Studies all indicated that Alabama's greatest need and highest prevalence remain in Alabama's six (6) metropolitan areas: Birmingham, Mobile, Huntsville, Montgomery, Dothan and Tuscaloosa. Both funding and planning strategies continue to concentrate on these areas with additional services being strengthened in the rural areas.

Prevention Needs Assessment:

The SASD Applied for a needs assessment grant during FFY 1998 and was not funded. The SASD was notified of another opportunity to apply during FFY 1999. An application was submitted and funding was approved. A total of $863,000 has been made available over a four-year period. The studies began October 1, 1999, a no-cost contract extension was received and the project was completed September 30, 2003.

Prevention Resource Allocation:

The prevention needs assessment data is used by the local 310 Boards, in conjunction with local prevention planning partners, to develop Catchment Area* prevention plans that identify priority populations and the specific prevention strategies to be applied to each priority population. The plans are subsequently submitted to the SASD for review, approval and funding.

* Catchment Area: Alabama has 67 counties. For planning and service delivery purposes these counties are divided into 22 Catchment Areas. The Catchment Areas vary in size from one county to five counties depending on their population.

A description of the studies and goals follows:
A. The Family of Studies
1. Conceptual and Theoretical Framework

The overarching conceptual framework that will be used to coordinate Alabama¿s family of studies is the risk and protective factor model. While a variety of risk and protective models exist, this family of studies will use the Broader Risk and Protective Factor Model (Hawkins, Catalano, & Miller, 1992) will serve as the basis for Alabama's approach to prevention needs assessment. In general, risk and protective factors are individual, family, school, social group and community characteristics that lend themselves to increased (risk) or decreased (protective) chances that substance use and abuse will occur in the environment.
2. Nature and Scope of Component Studies

The school survey will provide information to document risk and protective factor levels among Alabama¿s youth. The social indicator study, which will use data collected by state agencies, will be used with survey data to develop a statewide and substate description of the states needs (risk factors) and resources (protective characteristics that buffer and/or modify risk). These data will be compared with information gathered in the Resource Assessment

Study. The Resource Assessment Study is designed to identify prevention activities in the state addressing risk and protective factors considered important in this theoretical model. This study will enable the Division to determine if the current system provides the proper mix of services as indicated by need identified in the School Survey and the Social Indicator Study. Moreover, the Resource Assessment Study data will be used to determine gaps and overlap in the current service delivery system.

In addition to more traditional survey and social indicator data analytic methods, this project will also use a Geographic Information System (GIS) as the basis for comparing existing resource to levels of need. This method combines the data elements gathered during the needs assessment into an easy to understand display. Through the GIS, the needs assessment data can be used to determine the location and demographics of the populations in need of prevention services. The GIS is a computer system designed to collect, store, retrieve, and manipulate display data linked to a geographic location. The data from each of these studies will be validated, integrated, and analyzed using modeling and other statistical procedures to develop a statewide prevention plan in the Integration and Planning study.

2. Provide a definition of the substate planning areas.

Substate Planning Regions:

Alabama is divided into twenty-two mental health catchment areas and four regions (maps attached). The catchment areas were designated in the late 1960's with the enactment of Act 310 by the Alabama Legislature. Act 310 created local 310 boards that were responsible for the planning and coordination of mental health, mental retardation, substance abuse and epilepsy services. Local city and county governments appoint these local 310 board members. The board members serve to represent the needs of the local communities regarding the services provided.

In 1991 the SASD divided Alabama into four regions (map attached) for the purposes of planning services and allocating resources since it was not practical to expect that a full continuum of substance abuse services could be provided on a catchment area basis. Population, proximity of catchment areas, major metropolitan areas and the location of residential programs were all taken into consideration when making the divisions.

3. Indicate whether or not the State is using the same substate planning areas definition that is also used for the State Treatment Needs Assessment Program.

The same four regions are used to analyze and apply the needs assessment results.

4. Identify what data is collected, how it is collected, and how it is used in making decisions.

Capacity and Utilization Levels:

Service data is submitted to the SASD by each contracting program. These data identify each unit of service provided and is accompanied with a client profile for each client served. Capacity and utilization levels are actual reported services from individual providers that are then summed to represent regional totals. This is how Alabama reports that the numbers reported are ¿verifiable¿. Fiscal year admission, service and actuarial reports are prepared, analyzed and shared with planning entities to assist in making decisions. These publications are available for review on the SASD website.

5. If the State used Statewide, regional or local advisory councils, explain their role(s) in the planning process.

State Planning:

The Substance Abuse Services Division must provide for a systematic long range and operational planning process that recognizes the statutory authority of both the Department, established under 22-50-1, et. seq. (Act 881), to set up state plans, and the Regional Mental Health Boards, established under 22-51-1, et. seq. (Act 310), to conduct local community planning.

Planning efforts for the Department include all services (treatment and prevention) to all populations.

In efforts to meet both obligations the Management Steering Committee was formed. This committee is charged with numerous responsibilities, one of which is the establishment of a coordinating subcommittee to facilitate development of a plan for substance abuse services through a collaborative effort between the Department, the 310 Boards, family members of consumers, and primary consumers. This coordinating subcommittee is responsible for integrating local and regional plans with statewide planning, consistent with strategic directions established by the Management Steering Committee.

The Substance Abuse Coordinating Subcommittee includes the following members:

- Mr. Ronald Hunt, Consumer/Advocate, Montgomery
- Ms. Gwen Thomas-LaBlanc, Advocate, Jasper
- Ms. Virginia Guy, Provider, Mobile
- Ms. MaryLou Street, Provider, Birmingham
- Mr. Bill Layfield, NCADD, Mobile
- Ms. Joan Bowen, Family Member/Advocate, Springville
- Mr. Philip Drane, Consumer/Advocate, Mobile
- Ms. Melissa Kirkland, Provider, Dothan
- Mr. Fred Armstead, Provider, Birmingham
- Dr. Jim Dill, Advocate, Birmingham
- Mr. Mike McLemore, Consumer Advocate, Decatur
- Mr. J. Kent Hunt, Associate Commissioner for Substance Abuse, Montgomery
- Ms. Sarah Harkless, Executive Assistant to the Associate Commissioner, Birmingham

The Management Steering Committee, Coordinating Subcommittee, the Council of Community Mental Health Boards, and the numerous substance abuse work groups made up of consumers, family members of consumers and providers of treatment and prevention services are involved with all aspects of planning and implementation of the services offered to the citizens of Alabama.

6. Describe the monitoring process utilized to assure that funded programs serve communities with the highest prevalence and greatest need.

The Office of Training and Workforce Development of the SASD is responsible for constant, consistent and comprehensive monitoring of SASD-funded programs to insure service delivery is compatible and consistent with Needs Assessment and planning processes. These 'site-visits' consist of lengthy program visits where both data review and consultation with agency staff are assessed to insure adherence to approved program descriptions. In addition, the SASD conducts frequent review of the comprehensive data that is collected from funded providers. These data are extensively analyzed to further insure compliance with the planning process.

7. Describe how the State determined the resources (capacity and utilization levels) available for the State as a whole and for each substate planning area.

Allocation of Prevention Resources:

The SASD allocates prevention funds based on a per capita basis and through a local planning process involving key community organizations.

Per Capita:

Alabama is divided into twenty-two Mental Health Catchment Areas. Each Mental Health Catchment Area signifies a local 310 board made up of board members appointed by local governments. The Catchment Areas are comprised of one to six counties (see attached map). Each 310 Board directs a local prevention planning process which includes key local organizations. The groups responsibilities are to analyze prevention needs, identify priorities, identify the prevention strategies to be applied, and develop outcome measures. The plans include an agreed upon funding scheme for the provision of the services. These plans are then submitted to the SASD for review and approval.

If an agreed upon local plan cannot be submitted, or if a submitted plan cannot be approved, the SASD will issue a Request for Proposals (RFP) for the particular Catchment Areas. Funding will then be made available to the selected provider.

Additional Prevention Funding:

The remainder of the SASD prevention funding is awarded to:

1. Operate two regional clearinghouses to provide training and resources to the prevention providers within each region.

2. As per section 1941 of the Interim Final Rule, describe the process employed to facilitate public comment in developing the State's plan and its FY 2005 application for substance abuse prevention and treatment block grant funds.

Public Comment:

In the past Alabama conducted regional meetings to elicit public comments on the Block Grant Application and the plans for substance abuse prevention and treatment services. After three years of receiving practically no responses, the SASD decided that these meetings were not yielding the desired results so they were discontinued.

Following the discontinuation of the public meetings SASD began publishing a notice inviting comments on the Block Grant Application and the plans for substance abuse services in the major newspapers in Alabama. After several years of receiving no comments this effort was abandoned.

With the creation of the Management Steering Committee (made up of consumers, advocates and providers), the Substance Abuse Coordinating Subcommittee (made up of consumers, advocates and providers) and the constant communication with the local 310 boards it is thought that the Block Grant Application and the planning for substance abuse services receives a considerable amount of public comment. The SASD plans to identify the Block Grant Application and the plans for substance abuse services on the DMH/MR. The SASD also plans to reinstitute the publication of the notice inviting comment on the Block Grant Application and the plans for substance abuse services in the major newspapers in Alabama.

During FFY 2000 the SASD ran notices in the major metropolitan newspapers in the state inviting comments on the Block Grant Application. A total of six responses were received and incorporated into the planning process.

As described in the previous paragraph the SASD ran announcements in the major newspapers within the state inviting comments on the Block Grant Application.

Six responses were received at the cost of approximately $800.

In light of the high cost and small response the SASD decided to rely on the input through the Management Steering Process, which includes consumer participation, and the annual budget presentations that the Commissioner is required to make before legislature. The Management Steering Process is ongoing and has already been described in this application. Commissioner John Houston presents the Department of Mental Health and Mental Retardation's budget request (which includes substance abuse) to the legislature each year. The Block Grant application is now available for review on the Alabama Department of Mental Health and Mental Retardation website at www.mh.alabama.gov.

State:
Alabama

Criteria for Allocating Funds

Use the following checklist to indicate the criteria your State will use in deciding how to allocate FY 2008 block grant funds. Mark all criteria that apply. Indicate the priority of the criteria by placing numbers in the boxes. For example, if the most important criterion is 'incidence and prevalence levels', put a '1' in the box beside that option. If two or more criteria are equal, assign them the same number.

2 Population levels, Specify formula:
$1.07 Per Capita

1 Incidence and prevalence levels

_ Problem levels as estimated by alcohol/drug-related crime statistics

4 Problem levels as estimated by alcohol/drug-related health statistics

3 Problem levels as estimated by social indicator data

1 Problem levels as estimated by expert opinion

_ Resource levels as determined by (specific method)

_ Size of gaps between resources (as measured by)

and needs (as estimated by)

_ Other (specify):

Treatment Needs Assessment Summary Matrix

State:	Calendar Year:
Alabama	2006

		3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		6. Prevalence of substance-related criminal activity			7. Incidence of communicable diseases		
1. Substate Planning Area	2. Total Population	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other:	A. Hepatitis B / 100,000	B. AIDS / 100,000	C. Tuberculosis / 100,000
Region 1	1,242,764	81,874	12,281	1,637	246	24,563	3,684	4,345	3,822	0	1	5	5
Region 2	1,454,916	98,410	14,762	1,968	295	25,558	3,834	4,154	6,094	0	2	12	4
Region 3	808,237	71,165	10,675	1,423	234	21,350	3,202	1,764	2,356	0	24	17	5
Region 4	1,007,483	71,583	10,737	1,431	215	21,475	3,221	2,760	5,093	0	2	12	3

Treatment Needs Assessment Summary Matrix

State:	Calendar Year:
Alabama	2006

		3. Total Population in need		4. Number of IVDUs in need		5. Number of women in need		6. Prevalence of substance-related criminal activity			7. Incidence of communicable diseases		
1. Substate Planning Area	2. Total Population	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Needing treatment services	B. That would seek treatment	A. Number of DWI arrests	B. Number of drug-related arrests	C. Other:	A. Hepatitis B / 100,000	B. AIDS / 100,000	C. Tuberculosis / 100,000
State Total	**4,513,400**	**323,032**	**48,455**	**6,459**	**969**	**92,946**	**13,941**	**13,031**	**17,365**	**0**	**2**	**11**	**4**

Form 8 Footnotes
The data in Forms 8 and 9 (columns 3,4 and 5) indicating the numbers of individuals needing treatment and those that would seek treatment were provided through the CSAT funded needs assessment completed in 1999. Alabama is pursuing updated prevention and treatment needs assessment studies that will provide the required level of detail to be included in the 2009 SAPT Block Grant application.

Data reported in columns 6 and 7 are collected from the relevant state agency maintained data bases and is used as social indicators of substance abuse/addiction for planning purposes.

Treatment Needs by Age, Sex, and Race/Ethnicity

State:	Substate Planning Area [95]:
Alabama	State Total

AGE GROUP	A. TOTAL	B. WHITE		C. BLACK OR AFRICAN AMERICAN		D. NATIVE HAWAIIAN / OTHER PACIFIC ISLANDER		E. ASIAN		F. AMERICAN INDIAN / ALASKA NATIVE		G. MORE THAN ONE RACE REPORTED		H. UNKNOWN		I. NOT HISPANIC OR LATINO		J. HISPANIC OR LATINO	
		M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F	M	F
1. 17 and under	14,356	8,836	3,787	1,213	520	0	0	0	0	0	0	0	0	0	0	0	0	0	0
2. 18 - 24		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
3. 25 - 44	308,676	178,318	70,758	41,719	17,881	0	0	0	0	0	0	0	0	0	0	0	0	0	0
4. 45 - 64		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
5. 65 and over		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
6. Total	323,032	187,154	74,545	42,932	18,401														

OMB No. 0930-0080 Approved: 09/30/2007 Expires: 09/30/2010

Form 9 Footnotes
Data is not available to complete columns D,E,F,G,H,I or J. The needs assessment study which was funded by CSAT and completed on 1999 did not provide the level of race/ethnicity required in FORM 9. Alabama is pursuing updated prevention and treatment needs assessment studies that will provide the required level of detail to be included in the 2009
SAPT Block Grant application.

Alabama

How your State determined the estimates for Form 8 and Form 9

How your State determined the estimates for Form 8 and Form 9

Under 42 U.S.C. 300x-29 and 45 C.F.R. 96.133, States are required to submit annually a needs assessment. This requirement is not contingent on the receipt of Federal needs assessment resources. States are required to use the best available data. Using up to three pages, explain what methods your State used to estimate the numbers of people in need of substance abuse treatment services, the biases of the data, and how the State intends to improve the reliability and validity of the data. Also indicate the sources and dates or timeframes for the data used in making these estimates reported in both Forms 8 and 9. In addition, provide any necessary explanation of the way your State records data or interprets the indices in columns 6 and 7.

Alabama "did" use CSAT Assessment Data.

State:
Alabama

INTENDED USE PLAN

(Include ONLY Funds to be spent by the agency administering the block grant. Estimated data are acceptable on this form)

OMB No. 0930-0080 Approved: 09/28/2007 Expires: 09/30/2010

SOURCE OF FUNDS

(24 Month Projection)

Activity (see instructions for using Row 1)	A. FY 2008 SAPT Block Grant	B. Medicaid (Federal, State and Local)	C. Other Federal Funds (e.g., Medicare, other public welfare)	D. State Funds	E. Local Funds (excluding local Medicaid)	F. Other
1. Substance abuse treatment and rehabilitation	$16,637,413	$6,376,256	$0	$14,392,142	$0	$6,885,916
2. Primary Prevention	$4,753,547		$3,250,000	$0	$0	$0
3. Tuberculosis Services	$0	$0	$0	$0	$0	$0
4. HIV Early Intervention Services	$1,188,387	$0	$0	$0	$0	$0
5. Administration (excluding program/provider level)	$1,188,386		$0	$974,982	$0	$0
6. Column Total	$23,767,733	$6,376,256	$3,250,000	$15,367,124	$	$6,885,916

Form 11 Footnotes
The Alabama FY 2008 SAPT Block Grant Intended Use Plan was amended.

Form 11ab

State:
Alabama

Form 11a: Primary Prevention Planned Expenditures Checklist

	Block Grant FY 2008	Other Federal	State	Local	Other
Information Dissemination	**$380,275**	**$**	**$**	**$**	**$**
Education	**$2,909,101**	**$**	**$**	**$**	**$**
Alternatives	**$760,549**	**$**	**$**	**$**	**$**
Problem Identification & Referral	**$42,781**	**$**	**$**	**$**	**$**
Community-Based Process	**$76,055**	**$**	**$**	**$**	**$**
Environmental	**$313,727**	**$**	**$**	**$**	**$**
Other	**$270,946**	**$**	**$**	**$**	**$**
Section 1926 - Tobacco	**$**	**$**	**$**	**$**	**$**
TOTAL	**$4,753,434**	**$**	**$**	**$**	**$**

Form 11b: Primary Prevention Planned Expenditures Checklist

	Block Grant FY 2008	Other Federal	State	Local	Other
Universal Direct	**$**	**$**	**$**	**$**	**$**
Universal Indirect	**$**	**$**	**$**	**$**	**$**
Selective	**$**	**$**	**$**	**$**	**$**
Indicated	**$**	**$**	**$**	**$**	**$**
TOTAL	**$**	**$**	**$**	**$**	**$**

Form 11c

State:
Alabama

Resource Development Planned Expenditure Checklist

Does your State plan to fund resource development activities with FY 2008 funds?

☐ Yes ☒ No

	Treatment	Prevention	Additional Combined	Total
Planning, Coordination and Needs Assessment	**$**	**$**	**$**	**$**
Quality Assurance	**$**	**$**	**$**	**$**
Training (post-employment)	**$**	**$**	**$**	**$**
Education (pre-employment)	**$**	**$**	**$**	**$**
Program Development	**$**	**$**	**$**	**$**
Research and Evaluation	**$**	**$**	**$**	**$**
Information Systems	**$**	**$**	**$**	**$**
TOTAL	**$**	**$**	**$**	**$**

Form 12

State:
Alabama

TREATMENT CAPACITY MATRIX

This form contains data covering a 24-month projection for the period during which your principal agency of the State is permitted to spend the FY 2008 block grant award.

Level of Care	A. Number of Admissions	B. Number of Persons Served
Detoxification (24 hour Care)		
1. Hospital Inpatient		
2. Free-standing Residential	**1,958**	**1,968**
Rehabilitation / Residential		
3. Hospital Inpatient		
4. Short-term (up to 30 days)	**7,442**	**8,020**
5. Long-term (over to 30 days)	**3,322**	**3,442**
Ambulatory (Outpatient)		
6. Outpatient		
7. Intensive Outpatient	**51,486**	**61,830**
8. Detoxification		
9. Opioid Replacement Therapy	**1,018**	**1,090**

OMB No. 0930-0080 Approved: 09/30/2007 Expires: 09/30/2010

State:
Alabama

Purchasing Services

Methods for Purchasing This item requires completing two checklists

There are many methods the State can use to purchase substance abuse services. Use the following checklist to describe how your State will purchase services with the FY 2008 block grant award. Indicate the proportion of funding that is expended through the applicable procurement mechanism.

☐	Competitive grants	Percent of Expense: %
☒	Competitive contracts	Percent of Expense: 10%
☐	Non-competitive grants	Percent of Expense: %
☒	Non-competitive contracts	Percent of Expense: 90%
☐	Statutory or regulatory allocation to governmental agencies serving as umbrella agencies that purchase or directly operate services	Percent of Expense: %
☐	Other	Percent of Expense: %

(The total for the above categories should equal 100 percent.)

☒	According to county or regional priorities	Percent of Expense: 20%

Methods for Determining Prices

There are also alternative ways a State can decide how much it will pay for services. Use the following checklist to describe how your State pays for services. Complete any that apply. In addressing a States allocation of resources through various payment methods, a State may choose to report either the proportion of expenditures or proportion of clients served through these payment methods. Estimated proportions are acceptable.

☐	Line item program budget	Percent of Clients Served: % Percent of Expenditures: %
☐	Price per slot	Percent of Clients Served: % Percent of Expenditures: %

Rate: Type of slot:

Rate: Type of slot:

Rate: Type of slot:

☒	Price per unit of service	Percent of Clients Served: 100% Percent of Expenditures: 100%
	Unit: Adult IOP	Rate: 14
	Unit: CR	Rate: 68
	Unit: RR	Rate: 45

☐ Per capita allocation (Formula):

Percent of Clients Served: %
Percent of Expenditures: %

☐ Price per episode of care:

Percent of Clients Served: %
Percent of Expenditures: %

Rate: Diagnostic Group:

Rate: Diagnostic Group:

Rate: Diagnostic Group:

State:
Alabama

Program Performance Monitoring

☒ On-site inspections

(Frequency for treatment:) 1 or 2 years; Meth is 1 year

(Frequency for prevention:) 1 or 2 years

☒ Activity Reports

(Frequency for treatment:) Monthly

(Frequency for prevention:) Monthly

☒ Management information System

☒ Patient/participant data reporting system

(Frequency for treatment:) Monthly

(Frequency for prevention:) Monthly

☒ Performance Contracts

☐ Cost reports

☒ Independent Peer Review

☒ Licensure standards - programs and facilities

(Frequency for treatment:) 1 or 2 years; Meth is 1 year

(Frequency for prevention:) 1 or 2 years

☒ Licensure standards - personnel

(Frequency for treatment:) 1 or 2 years; Meth is 1 year

(Frequency for prevention:) 1 or 2 years

☐ Other (Specify):

Performance Measure Data Collection
Interim Standard – Change in Employment Status
(from Admission to Discharge)

GOAL To improve the employment status of persons treated in the State's substance abuse treatment system.

MEASURE The change in *all clients receiving treatment* who reported being employed (including part-time) at discharge.

DEFINITIONS Change in *all clients receiving treatment* who reported being employed (including part-time) at admission and discharge.

Most recent year for which data are available	From:	To:

Employment Status – Clients employed (full-time and part-time) (prior 30 days) at admission vs. discharge	**Admission Clients (T_1)**	**Discharge Clients (T_2)**
Number of clients employed (full-time and part-time) [numerator]	8,331	844
Total number of clients with non-missing values on employment status [denominator]	19,047	2,716
Percent of clients employed (full-time and part-time)	**43.74%**	**31.08%**
Percent of clients employed (full-time and part-time) at discharge minus percent of clients employed at admission. (Positive percent change values indicate increased employment)	Absolute Change [$\%T_2$-$\%T_1$] **-12.66% / -28.95%**	

State Description of Employment Status Data Collection (Form T1)

STATE CONFORMANCE TO INTERIM STANDARD	**States should detail exactly how this information is collected. Where data and methods vary from interim standard, variance should be described**

DATA SOURCE	**What is the source of data for table T1? (Select all that apply)** ☑ Client Self Report Client self-report confirmed by another source: ☐ Collateral source ☑ Administrative data source ☐ Other: Specify

EPISODE OF CARE	**How is the admission/discharge basis defined for table T1? (Select one)** ○ Admission is on the first date of service, prior to which no service has bee received for 30 days AND discharge is on the last date of service, subsequent to which no service has been received for 30 days ◉ Admission is on the first date of service in a Program/Service Delivery Unit and Discharge is on the last

date of service in a Program/Service Delivery Unit

○ Other, Specify:

DISCHARGE DATA COLLECTION

How was discharge data collected for table T1? (Select all that apply)

☐ Not applicable, data reported on form is collected at time period other than discharge
Specify:

- ○ In-Treatment data ____ days post admission
- ○ Follow-up data ____ months post admission
- ○ Other, Specify:

☐ Discharge data is collected for the census of all (or almost all) clients who were admitted to treatment

☐ Discharge data is collected for a sample of all clients who were admitted to treatment

☑ Discharge records are directly collected (or in the case of early dropouts) are created for all (or almost all) clients who were admitted to treatment

☐ Discharge records are not collected for approximately ____ % of clients who were admitted for treatment

RECORD LINKING

Was the admission and discharge data linked for table T1? (Select all that apply)

☑ Yes, all clients at admission were linked with discharge data using an Unique Client Identifier (UCID)
Select type of UCID:

- ○ Master Client Index or Master Patient Index, centrally assigned
- ○ Social Security Number (SSN)
- ○ Unique client ID based on fixed client characteristics (such as date of birth, gender, partial SSN, etc.)
- ○ Some other Statewide unique ID
- ◉ Provider-entity-specific unique ID

☐ No, State Management Information System does not utilize UCID that allows comparison of admission and discharge data on a client specific basis (data developed on a cohorts basis) or State relied on other data sources for post admission data

☐ No, admission and discharge records were matched using probabilistic record matching

IF DATA IS UNAVAILABLE

If data is not reported, why is State unable to report? (Select all that apply)

☐ Information is not collected at admission

☐ Information is not collected at discharge

☐ Information is not collected by the categories requested

☐ State collects information on the indicator area but utilizes a different measure.

DATA PLANS IF DATA IS NOT AVAILABLE

State must provide time-framed plans for capturing employment status data on all clients, if data is not currently available. Plans should also discuss barriers, resource needs and estimates of cost.

Performance Measure Data Collection
Interim Standard – Number of Clients and Change in Homelessness (Living Status)

GOAL To improve living conditions of persons treated in the State's substance abuse treatment system.

MEASURE The change in *all clients receiving treatment* who reported being homeless at discharge.

DEFINITIONS Change in *all clients receiving treatment* who reported being homeless at discharge equals the clients reporting being homeless at admission subtracted from the clients reporting being homeless at discharge.

Most recent year for which data are available	From: 10/1/2006	To: 8/31/2007

Homelessness – Clients homeless (prior 30 days) at admission vs. discharge	**Admission Clients (T_1)**	**Discharge Clients (T_2)**
Number of clients homeless [numerator]	1,461	557
Total number of clients with non-missing values on living arrangements [denominator]	19,047	3,220
Percent of clients homeless	**7.67%**	**17.30%**
Percent of clients homeless at discharge minus percent of clients homeless at admission. (Negative percent change values indicate reduced homelessness)	Absolute Change [$\%T_2$-$\%T_1$] **9.63% / 125.52%**	

State Description of Homelessness (Living Status) Data Collection (Form T2)

STATE CONFORMANCE TO INTERIM STANDARD	**States should detail exactly how this information is collected. Where data and methods vary from interim standard, variance should be described**

DATA SOURCE	**What is the source of data for table T2? (Select all that apply)** ☑ Client Self Report Client self-report confirmed by another source: ☐ Collateral source ☑ Administrative data source ☐ Other: Specify

EPISODE OF CARE	**How is the admission/discharge basis defined for table T2? (Select one)** ○ Admission is on the first date of service, prior to which no service has bee received for 30 days AND discharge is on the last date of service, subsequent to which no service has been received for 30 days

	◉ Admission is on the first date of service in a Program/Service Delivery Unit and Discharge is on the last date of service in a Program/Service Delivery Unit ○ Other, Specify:
DISCHARGE DATA COLLECTION	**How was discharge data collected for table T2? (Select all that apply)** ☐ Not applicable, data reported on form is collected at time period other than discharge Specify: ○ In-Treatment data ____ days post admission ○ Follow-up data ____ months post admission ○ Other, Specify: ____ ☐ Discharge data is collected for the census of all (or almost all) clients who were admitted to treatment ☐ Discharge data is collected for a sample of all clients who were admitted to treatment ☑ Discharge records are directly collected (or in the case of early dropouts) are created for all (or almost all) clients who were admitted to treatment ☐ Discharge records are not collected for approximately ____ % of clients who were admitted for treatment
RECORD LINKING	**Was the admission and discharge data linked for table T2? (Select all that apply)** ☑ Yes, all clients at admission were linked with discharge data using an Unique Client Identifier (UCID) Select type of UCID: ○ Master Client Index or Master Patient Index, centrally assigned ○ Social Security Number (SSN) ○ Unique client ID based on fixed client characteristics (such as date of birth, gender, partial SSN, etc.) ○ Some other Statewide unique ID ◉ Provider-entity-specific unique ID ☐ No, State Management Information System does not utilize UCID that allows comparison of admission and discharge data on a client specific basis (data developed on a cohorts basis) or State relied on other data sources for post admission data ☐ No, admission and discharge records were matched using probabilistic record matching
IF DATA IS UNAVAILABLE	**If data is not reported, why is State unable to report? (Select all that apply)** ☐ Information is not collected at admission ☐ Information is not collected at discharge ☐ Information is not collected by the categories requested ☐ State collects information on the indicator area but utilizes a different measure.
DATA PLANS IF DATA IS NOT AVAILABLE	**State must provide time-framed plans for capturing living status data on all clients, if data is not currently available. Plans should also discuss barriers, resource needs and estimates of cost.**

Performance Measure Data Collection
Interim Standard – Change of Persons Arrested

GOAL To reduce the criminal justice involvement of persons treated in the State's substance abuse treatment system.

MEASURE The change in persons arrested in the last 30 days at discharge for *all clients receiving treatment*.

DEFINITIONS Change in persons arrested in the last 30 days at discharge for *all clients receiving treatment* equals clients who were arrested in the 30 days prior to admission subtracted from clients who were arrested in the last 30 days at discharge. An arrest is any arrest.

Most recent year for which data are available	From: 10/1/2006	To: 8/31/2007

Arrests – Clients arrested (any charge) (prior 30 days) at admission vs. discharge	**Admission Clients (T_1)**	**Discharge Clients (T_2)**
Number of Clients arrested [numerator]	688	176
Total number of clients with non-missing values on arrests [denominator]	5,888	1,561
Percent of clients arrested	**11.68%**	**11.27%**
Percent of clients arrested at discharge minus percent of clients arrested at admission. (Negative percent change values indicate reduced arrests)	Absolute Change [$\%T_2$-$\%T_1$] **-0.41% / -3.51%**	

State Description of Number of Arrests Data Collection (Form T3)

STATE CONFORMANCE TO INTERIM STANDARD	**States should detail exactly how this information is collected. Where data and methods vary from interim standard, variance should be described**

DATA SOURCE	**What is the source of data for table T3? (Select all that apply)** ☑ Client Self Report Client self-report confirmed by another source: ☐ Collateral source ☑ Administrative data source ☐ Other: Specify

EPISODE OF CARE	**How is the admission/discharge basis defined for table T3? (Select one)** ○ Admission is on the first date of service, prior to which no service has bee received for 30 days AND discharge is on the last date of service, subsequent to which no service has been received for 30 days

	◉ Admission is on the first date of service in a Program/Service Delivery Unit and Discharge is on the last date of service in a Program/Service Delivery Unit ○ Other, Specify:
DISCHARGE DATA COLLECTION	**How was discharge data collected for table T3? (Select all that apply)** ☐ Not applicable, data reported on form is collected at time period other than discharge Specify: ○ In-Treatment data ____ days post admission ○ Follow-up data ____ months post admission ○ Other, Specify: ☐ Discharge data is collected for the census of all (or almost all) clients who were admitted to treatment ☐ Discharge data is collected for a sample of all clients who were admitted to treatment ☑ Discharge records are directly collected (or in the case of early dropouts) are created for all (or almost all) clients who were admitted to treatment ☐ Discharge records are not collected for approximately ____ % of clients who were admitted for treatment
RECORD LINKING	**Was the admission and discharge data linked for table T3? (Select all that apply)** ☑ Yes, all clients at admission were linked with discharge data using an Unique Client Identifier (UCID) Select type of UCID: ○ Master Client Index or Master Patient Index, centrally assigned ○ Social Security Number (SSN) ○ Unique client ID based on fixed client characteristics (such as date of birth, gender, partial SSN, etc.) ○ Some other Statewide unique ID ◉ Provider-entity-specific unique ID ☐ No, State Management Information System does not utilize UCID that allows comparison of admission and discharge data on a client specific basis (data developed on a cohorts basis) or State relied on other data sources for post admission data ☐ No, admission and discharge records were matched using probabilistic record matching
IF DATA IS UNAVAILABLE	**If data is not reported, why is State unable to report? (Select all that apply)** ☐ Information is not collected at admission ☐ Information is not collected at discharge ☐ Information is not collected by the categories requested ☐ State collects information on the indicator area but utilizes a different measure.
DATA PLANS IF DATA IS NOT AVAILABLE	**State must provide time-framed plans for capturing arrest data on all clients, if data is not currently available. Plans should also discuss barriers, resource needs and estimates of cost.**

Performance Measure Data Collection
Interim Standard – Percentage Point Change in Abstinence - Alcohol Use

GOAL To reduce substance abuse to protect the health, safety, and quality of life for all.

MEASURE The change in *all clients receiving treatment* who reported abstinence at discharge.

DEFINITIONS Change in *all clients receiving treatment* who reported abstinence at discharge equals clients reporting abstinence at admission subtracted from clients reporting abstinence at discharge.

Most recent year for which data are available	From: 10/1/2006	To: 8/31/2007

Alcohol Abstinence – Clients with no alcohol use (all clients regardless of primary problem) (use Alcohol Use in last 30 days field) at admission vs. discharge.	**Admission Clients (T_1)**	**Discharge Clients (T_2)**
Number of clients abstinent from alcohol [numerator]	11,838	3,630
Total number of clients with non-missing values on "used any alcohol" variable [denominator]	19,047	3,937
Percent of clients abstinent from alcohol	**62.15%**	**92.20%**
Percent of clients abstinent from alcohol at discharge minus percent of clients abstinent from alcohol at admission. (Positive percent change values indicate increased alcohol abstinence)	Absolute Change [$\%T_2$-$\%T_1$] **30.05% / 48.35%**	
(1) If State does not have a "used any alcohol" variable, calculate instead using frequency of use variables for all primary, secondary, or tertiary problem codes in which the coded problem is Alcohol (e.g. ,TEDS Code 02)		

State Description of Alcohol Use Data Collection (Form T4)

STATE CONFORMANCE TO INTERIM STANDARD	**States should detail exactly how this information is collected. Where data and methods vary from interim standard, variance should be described**

DATA SOURCE	**What is the source of data for table T4? (Select all that apply)** ☑ Client Self Report Client self-report confirmed by another source: ☐ Urinalysis, blood test or other biological assay ☐ Collateral source ☑ Administrative data source ☐ Other: Specify

EPISODE OF CARE	**How is the admission/discharge basis defined for table T4? (Select one)** ○ Admission is on the first date of service, prior to which no service has bee received for 30 days AND discharge is on the last date of service, subsequent to which no service has been received for 30 days ◉ Admission is on the first date of service in a Program/Service Delivery Unit and Discharge is on the last date of service in a Program/Service Delivery Unit ○ Other, Specify:
DISCHARGE DATA COLLECTION	**How was discharge data collected for table T4? (Select all that apply)** ☐ Not applicable, data reported on form is collected at time period other than discharge Specify: ○ In-Treatment data ____ days post admission ○ Follow-up data ____ months post admission ○ Other, Specify: ☐ Discharge data is collected for the census of all (or almost all) clients who were admitted to treatment ☐ Discharge data is collected for a sample of all clients who were admitted to treatment ☑ Discharge records are directly collected (or in the case of early dropouts) are created for all (or almost all) clients who were admitted to treatment ☐ Discharge records are not collected for approximately ____ % of clients who were admitted for treatment
RECORD LINKING	**Was the admission and discharge data linked for table T4? (Select all that apply)** ☑ Yes, all clients at admission were linked with discharge data using an Unique Client Identifier (UCID) Select type of UCID: ○ Master Client Index or Master Patient Index, centrally assigned ○ Social Security Number (SSN) ○ Unique client ID based on fixed client characteristics (such as date of birth, gender, partial SSN, etc.) ○ Some other Statewide unique ID ◉ Provider-entity-specific unique ID ☐ No, State Management Information System does not utilize UCID that allows comparison of admission and discharge data on a client specific basis (data developed on a cohorts basis) or State relied on other data sources for post admission data ☐ No, admission and discharge records were matched using probabilistic record matching
IF DATA IS UNAVAILABLE	**If data is not reported, why is State unable to report? (Select all that apply)** ☐ Information is not collected at admission ☐ Information is not collected at discharge ☐ Information is not collected by the categories requested ☐ State collects information on the indicator area but utilizes a different measure.
DATA PLANS IF DATA IS NOT AVAILABLE	**State must provide time-framed plans for capturing alcohol abstinance data on all clients, if data is not currently available. Plans should also discuss barriers, resource needs and**

	estimates of cost.

Performance Measure Data Collection
Interim Standard – Percentage Point Change in Abstinence - Other Drug Use

GOAL To reduce substance abuse to protect the health, safety, and quality of life for all.

MEASURE The change in *all clients receiving treatment* who reported abstinence at discharge.

DEFINITIONS Change in *all clients receiving treatment* who reported abstinence at discharge equals clients reporting abstinence at admission subtracted from clients reporting abstinence at discharge.

Most recent year for which data are available	From: 10/1/2006	To: 8/31/2007

Drug Abstinence – Clients with no drug use (all clients regardless of primary problem) (use Any Drug Use in last 30 days field) at admission vs. discharge.	**Admission Clients (T_1)**	**Discharge Clients (T_2)**
Number of Clients abstinent from illegal drugs [numerator]	3,212	3,111
Total number of clients with non-missing values on "used any drug" variable [denominator]	19,047	3,937
Percent of clients abstinent from drugs	**16.86%**	**79.02%**
Percent of clients abstinent from drugs at discharge minus percent of clients abstinent from drugs at admission. (Positive percent change values indicate increased drug abstinence)	Absolute Change [$\%T_2$-$\%T_1$] **62.16% / 368.58%**	
(2) If State does not have a "used any drug" variable, calculate instead using frequency of use variables for all primary, secondary, or tertiary problem codes in which the coded problem is Drugs (e.g., TEDS Codes 03-20)		

State Description of Drug Use Data Collection (Form T5)

STATE CONFORMANCE TO INTERIM STANDARD	**States should detail exactly how this information is collected. Where data and methods vary from interim standard, variance should be described**

DATA SOURCE	**What is the source of data for table T5? (Select all that apply)** ☑ Client Self Report Client self-report confirmed by another source: ☐ Urinalysis, blood test or other biological assay ☐ Collateral source ☑ Administrative data source ☐ Other: Specify

EPISODE OF CARE	**How is the admission/discharge basis defined for table T5? (Select one)** ○ Admission is on the first date of service, prior to which no service has bee received for 30 days AND discharge is on the last date of service, subsequent to which no service has been received for 30 days ◉ Admission is on the first date of service in a Program/Service Delivery Unit and Discharge is on the last date of service in a Program/Service Delivery Unit ○ Other, Specify:
DISCHARGE DATA COLLECTION	**How was discharge data collected for table T5? (Select all that apply)** ☐ Not applicable, data reported on form is collected at time period other than discharge Specify: ○ In-Treatment data ____ days post admission ○ Follow-up data ____ months post admission ○ Other, Specify: ☐ Discharge data is collected for the census of all (or almost all) clients who were admitted to treatment ☐ Discharge data is collected for a sample of all clients who were admitted to treatment ☑ Discharge records are directly collected (or in the case of early dropouts) are created for all (or almost all) clients who were admitted to treatment ☐ Discharge records are not collected for approximately ____ % of clients who were admitted for treatment
RECORD LINKING	**Was the admission and discharge data linked for table T5? (Select all that apply)** ☑ Yes, all clients at admission were linked with discharge data using an Unique Client Identifier (UCID) Select type of UCID: ○ Master Client Index or Master Patient Index, centrally assigned ○ Social Security Number (SSN) ○ Unique client ID based on fixed client characteristics (such as date of birth, gender, partial SSN, etc.) ○ Some other Statewide unique ID ◉ Provider-entity-specific unique ID ☐ No, State Management Information System does not utilize UCID that allows comparison of admission and discharge data on a client specific basis (data developed on a cohorts basis) or State relied on other data sources for post admission data ☐ No, admission and discharge records were matched using probabilistic record matching
IF DATA IS UNAVAILABLE	**If data is not reported, why is State unable to report? (Select all that apply)** ☐ Information is not collected at admission ☐ Information is not collected at discharge ☐ Information is not collected by the categories requested ☐ State collects information on the indicator area but utilizes a different measure.
DATA PLANS IF DATA IS NOT AVAILABLE	**State must provide time-framed plans for capturing drug abstinance data on all clients, if data is not currently available. Plans should also discuss barriers, resource needs and**

	estimates of cost.

Performance Measure Data Collection
Interim Standard – Percentage Point Change in Social Support of Recovery

GOAL To improve clients' participation in social support of recovery activities to reduce substance abuse to protect the health, safety, and quality of life for all.

MEASURE The change in *all clients receiving treatment* who reported participation in one or more social and or recovery support activity at discharge.

DEFINITIONS Change in *all clients receiving treatment* who reported participation in one or more social and recovery support activities at discharge equals clients reporting participation at admission subtracted from clients reporting participation at discharge.

Most recent year for which data are available	From:	To:

Social Support of Recovery – Clients participating in self-help groups, support groups (e.g., AA, NA, etc.) (prior 30 days) at admission vs. discharge	**Admission Clients (T_1)**	**Discharge Clients (T_2)**
Number of clients with one or more such activities (AA NA meetings attended, etc.) [numerator]	0	0
Total number of Admission and Discharge clients with non-missing values on social support activities [denominator]	0	0
Percent of clients participating in social support activities		
Percent of clients participating in social support of recovery activities in prior 30 days at discharge minus percent of clients participating in social support of recovery activities in prior 30 days at admission. (Positive percent change values indicate increased participation in social support of recovery activities.)	Absolute Change [$\%T_2$-$\%T_1$] **0.00% / 0.00%**	

State Description of Social Support of Recovery Data Collection (Form T6)

STATE CONFORMANCE TO INTERIM STANDARD	**States should detail exactly how this information is collected. Where data and methods vary from interim standard, variance should be described**

DATA SOURCE	**What is the source of data for table T6? (Select all that apply)** ☐ Client Self Report Client self-report confirmed by another source: ☐ Collateral source ☐ Administrative data source ☐ Other: Specify

EPISODE OF CARE	**How is the admission/discharge basis defined for table T6? (Select one)** ○ Admission is on the first date of service, prior to which no service has bee received for 30 days AND discharge is on the last date of service, subsequent to which no service has been received for 30 days ○ Admission is on the first date of service in a Program/Service Delivery Unit and Discharge is on the last date of service in a Program/Service Delivery Unit ○ Other, Specify:
DISCHARGE DATA COLLECTION	**How was discharge data collected for table T6? (Select all that apply)** ☐ Not applicable, data reported on form is collected at time period other than discharge Specify: ○ In-Treatment data ____ days post admission ○ Follow-up data ____ months post admission ○ Other, Specify: ☐ Discharge data is collected for the census of all (or almost all) clients who were admitted to treatment ☐ Discharge data is collected for a sample of all clients who were admitted to treatment ☐ Discharge records are directly collected (or in the case of early dropouts) are created for all (or almost all) clients who were admitted to treatment ☐ Discharge records are not collected for approximately ____ % of clients who were admitted for treatment
RECORD LINKING	**Was the admission and discharge data linked for table T6? (Select all that apply)** ☐ Yes, all clients at admission were linked with discharge data using an Unique Client Identifier (UCID) Select type of UCID: ○ Master Client Index or Master Patient Index, centrally assigned ○ Social Security Number (SSN) ○ Unique client ID based on fixed client characteristics (such as date of birth, gender, partial SSN, etc.) ○ Some other Statewide unique ID ○ Provider-entity-specific unique ID ☐ No, State Management Information System does not utilize UCID that allows comparison of admission and discharge data on a client specific basis (data developed on a cohorts basis) or State relied on other data sources for post admission data ☐ No, admission and discharge records were matched using probabilistic record matching
IF DATA IS UNAVAILABLE	**If data is not reported, why is State unable to report? (Select all that apply)** ☐ Information is not collected at admission ☐ Information is not collected at discharge ☐ Information is not collected by the categories requested ☐ State collects information on the indicator area but utilizes a different measure.
DATA PLANS IF DATA IS NOT AVAILABLE	**State must provide time-framed plans for capturing social support of recovery data on all clients, if data is not currently available. Plans should also discuss barriers, resource**

	needs and estimates of cost. In August of 2008, SASD will conduct a provider survey through ASAIS that will ascertain by provider, what percentage of clients participate in recover support activities at admission and what percentage are participating in recovery support activities at discharge. This information will be reported in the FY2009 SAPTBG application.

Page 208 of 240

Form T6 Footnotes
Data is currently not available.

a) We have been in a freeze on changes in our current data collection system until we implement our new web-based management information system. The collection of social support of recovery at both admission and discharge will begin upon that implementation, currently scheduled to go statewide in the summer of 2008.

Length of Stay (in Days) of All Discharges

Most recent year for which data are available	From:	To:

Length of Stay			
Level of Care	**Average**	**Median**	**Standard Deviation**
Detoxification (24-Hour Care)			
1. Hospital Inpatient			
2. Free-standing Residential			
Rehabilitation / Residential			
3. Hospital Inpatient			
4. Short-term (up to 30 days)			
5. Long-term (over 30 days)			
Ambulatory (Outpatient)			
6. Outpatient			
7. Intensive Outpatient			
8. Detoxification			
Opioid Replacement Therapy (ORT)			
9. ORT Detoxification (any setting)			
10. ORT Outpatient			

Form T7 Footnotes
The data required in FORM T-7 is currently not available. The SASD is in the process of implementing a new billing and data reporting system (Alabama þÿ S u b s t a n c e A b u s e I n f o r m a t i o n S y s t e m The A S A current system SUDS is locked down, allowing no changes since the new system is being implemented. The collection of length of stay will begin upon the implementation of ASAIS.

No barriers or increased costs are expected to prevent the completion of FORM T-7 upon ASAIS go live.

Alabama

INSERT OVERALL NARRATIVE:

INSERT OVERALL NARRATIVE:

The State should address as many of these questions as possible and may provide other relevant information if so desired. Responses to questions that are already provided in other sections of the application (e.g., planning, needs assessment) should be referenced whenever possible.

State Performance Management and Leadership

Describe the Single State Authority capacity and capability to make data driven decisions based on performance measures? Describe any potential barriers and necessary changes that would enhance the SSA's leadership role in this capacity.

Describe the types of regular and ad hoc reports generated by the State and identify to whom they are distributed and how.

If the State sets benchmarks, performance targets or quantified objectives, what methods are used by the State in setting these values?

What actions does the State take as a result of analyzing performance management data?

Has the State developed evidence-based practices (EBPs) or programs and, if so, does the State require that providers use these EBPs?

Provider Involvement

What actions does the State expect the provider or intermediary to take as a result of analyzing performance management data?

If the SSA has a regular training program for State and provider staff that collect and report client information, describe the training program, its participants and frequency.

Do workforce development plans address NOMs implementation and performance-based management practices?

Does the State require providers to supply information about the intensity or number of services received?

Describe the Single State Authority capacity and capability to make data driven decisions based on performance measures? Describe any potential barriers and þÿ n e c e s s a r y c h a n g e s t h a t w o u l d e n h a n c e t h e capacity.

The SASD has the capacity and capability to make data driven decisions based on performance measures. Preliminarily, the State Finance Office has implemented the Specific Measurable Accountable Responsive Transparent (SMART) process for budgeting which requires the identification of specific measurable goals for each state agency. The State Finance Office is supportive of performance contracting. The SASD has included outcome measurement in the substance abuse þÿ s e c t i o n o f t h e D e p a r t m e n t o f M e n t a l H e a l Budget Plan, however, the plan is limited to the data currently available. To þÿ e n h a n c e d a t a d r i v e n d e c i s i o n m a k i n g t h e þÿ I m p r o v e m e n t I n i t i a t i v e w h i c h w i l l p r o v i data to allow the establishment of performance measures for community substance abuse services. þÿ T h e c e n t e r p i e c e o f t h e S y s t e m Alabama Substance Abuse Information System (ASAIS) which includes standardized screening and assessment, waiting list management, billing, priority population management, data warehouse, outcomes collection and report writing capabilities. þÿ P o r t i o n s o f t h e S y s t e m I m p r o v e m implemented during the summer of 2008.

Of course barriers exist to full implementation of performance measurement and performance contracting. Changes based on performance are always challenged politically from the community provider level. The SASD began laying the foundation for performance contracting several years ago by making contract funding adjustments based on funding utilization. It is generally accepted that underutilization means funding shifts. Future opposition to implementation of performance contracting can be reduced by: incremental implementation of performance measurement concepts; inclusion of the community provider community in the implementation; extensive training; and extensive technical assistance to community providers aimed at improving performance.

Describe the types of regular and ad hoc reports generated by the State and identify to whom they are distributed and how.

The Specific Measurable Accountable Responsive Treatment (SMART) budget process requires quarterly reports to the State Finance Office which identify progress on the departmental budgeting goals.

Current community clinical and financial reporting is provided through the SASD þÿ d a t a a n d b i l l i n g T h e d a t a s e t c o l l e c t e d i n c l u d e s S U D S minimum demographic data, client service and financial specific data necessary to meet block grant reporting requirements. Ad hoc reports are created for analysis of areas such as diagnoses, volume of assessment without treatment, drug of abuse, etc.

The implementation of ASAIS will greatly expand the capability of report generating specifically performance management related data and the data warehouse capability will enhance the availability of the data for ad hoc analysis by providers, policy makers and the general public.

If the State sets benchmarks, performance targets or quantified objectives, what methods are used by the State in setting these values?

Alabama has collected outcome data for one year and is in the process of analyzing the data with intentions of establishing benchmarks.

What actions does the State take as a result of analyzing performance management data?

Alabama will initially use performance management data to identify needs for training and technical assistance. Once training and technical assistance have been provided ultimately performance management data will be used to shift resources to providers demonstrating the best performance.

þÿ H a s t h e S t a t e d e v e l o p e d e v i d e n c e - b a s e d p
þÿ s o , d o e s t h e S t a t e r e q u i r e t h a t p r o v i d e r

Evidence-based practices are recommended but not required. Alabama is adopting a new assessment and placement criteria that is compatible with the American Society of Addiction Medicine (ASAM) Levels of Care and is developing certification standards to support these levels of care.

Provider Involvement

What actions does the State expect the provider or intermediary to take as a result of analyzing performance management data?

Improvement is a partnership between the provider community and the SASD. The process must include agreed upon performance measures, acceptance of the findings, identification of a plan for improvement and consistent monitoring of progress. Ultimately, improved client care, as evidenced in outcomes, is expected.

If the SSA has a regular training program for State and provider staff that collect and report client information, describe the training program, its participants and frequency.

The SASD is in the process of implementing the Alabama Substance Abuse Information System (ASAIS). ASAIS is designed to collect and report performance data. Providers are undergoing rigorous training regarding the collection and reporting of client service, financial, waiting list, assessment, placement, and outcomes data. The training will continue after ASAIS go-live.

Do workforce development plans address NOMs implementation and performance-based management practices?

No Comment.

Does the State require providers to supply information about the intensity or number of services received?

Yes, all contracting community service providers report client specific detail regarding the type, number, and duration of all services provided.

Alabama

Treatment Corrective Action Plan (submit upon request)

1. Describe the corrective action plan, including critical steps and actions the State and its providers will employ to collect and report the National Outcome Measures data.

2. Discuss the timeframes for the State's corrective action plan detailing the planned milestones and other measures of progress the State has incorporated into its corrective action plan.

3. Describe the State's corrective action plan implementation monitoring activities including interventions or adjustments the State will employ when timeframes or milestones are not achieved.

As of July 1, 2008, with the go live of the Alabama Substance Abuse Information System (ASAIS), Alabama now collects the length of stay for each client, and will tie that back to their level of care. This will allow us to report one quarter of data on the FY2009 SAPT block grant application and meet the reporting requirement with a full year of data in the FY2010 SAPT block grant application.

þÿ D e s c r i b e A l a b a m a s a c t i o n p l a n a n d s t e p s
ASAIS implementation.

The Alabama Substance Abuse Information System (ASAIS) went live July 1, 2008. The SASD is working with all providers to assure smooth transition including client enrollment, service billing, reimbursement, waiting list management, NOMS reporting, etc. To date, the go live has been as smooth as one could expect with complete systems implementation.

þÿ W h a t i s t h e S t a t e s t i m e - f r a m e f o r c o l l e
for the SAPT Block Grant Application?

Alabama will report data for T6 and T7 in the 2009 application. The T6 information will be collected via survey and the T7 data is being collected through ASAIS from all providers beginning July 1, 2008.

Beginning October 1, 2008, Alabama will require all treatment providers to track change in Social Support of Recovery for all clients receiving substance abuse treatment services. A question will be added to the standard client profile completed at admission in the Alabama Substance Abuse Information System (ASAIS) that will ascertain whether a client has been involved in recovery support activity within the prior 30 days. The same question will be
þÿ a s k e d a t d i s c h a r g e a n d r e c o r d e d i n t h e c

What measures of progress will the State use to show plan objectives are met?

Beginning in late 2008, the Information Services section will generate National Outcome Measures (NOMS) reports to be distributed to all staff in the division and treatment providers to assess data quality, as well as accountability and effectiveness of Alabama treatment providers. The report will be generated on a monthly basis as an internal monitoring tool to ensure that NOMS data are being consistently submitted by all providers and follow-up will be conducted as needed for those who are not submitting data in a timely way.

Form P1

NOMs Domain: Reduced Morbidity—Abstinence from Drug Use/Alcohol Use
Measure: 30-Day Use

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
1. 30-day Alcohol Use	**Source Survey Item:** NSDUH Questionnaire. "Think specifically about the past 30 days, that is, from **[DATEFILL]** through today. During the past 30 days, on how many days did you drink one or more drinks of an alcoholic beverage?" [Response option: Write in a number between 0 and 30.] **Outcome Reported:** Percent who reported having used alcohol during the past 30 days.	Ages 12–17 - FFY 2005 (Baseline)	16.10	
		Ages 18+ - FFY 2005 (Baseline)	44.30	
2. 30-day Cigarette Use	**Source Survey Item:** NSDUH Questionnaire: "During the past 30 days, that is, since **[DATEFILL]**, on how many days did you smoke part or all of a cigarette?" [Response option: Write in a number between 0 and 30.]	Ages 12–17 - FFY 2005 (Baseline)	12.80	
		Ages 18+ - FFY 2005 (Baseline)	28.30	
3. 30-day Use of Other Tobacco Product	**Source Survey Item:** NSDUH Questionnaire: "During the past 30 days, that is, since **[DATEFILL]**, on how many days did you use [other tobacco products] † ?" [Response option: Write in a number between 0 and 30.] **Outcome Reported:** Percent who reported having used a tobacco product other than cigarettes during the past 30 days,	Ages 12–17 - FFY 2005 (Baseline)	9.40	
		Ages 18+ - FFY 2005 (Baseline)	10.20	
4. 30-day Use of Marijuana	**Source Survey Item:** NSDUH Questionnaire: "Think specifically about the past 30 days, from **[DATEFILL]** up to and including today. During the past 30 days, on how many days did you use marijuana or hashish?" [Response option: Write in a number between 0 and 30.] **Outcome Reported:** Percent who reported having used marijuana or hashish during the past 30 days.	Ages 12–17 - FFY 2005 (Baseline)	6.50	
		Ages 18+ - FFY 2005 (Baseline)	4	
5. 30-day Use of Illegal Drugs Other Than Marijuana	**Source Survey Item:** NSDUH Questionnaire: "Think specifically about the past 30 days, from **[DATEFILL]** up to and including today. During the past 30 days, on how many days did you use [any other illegal drug] ‡ ?" **Outcome Reported:** Percent who reported having used illegal drugs other than marijuana or hashish during the past 30 days, calculated by combining responses to questions about individual drugs (heroin, cocaine, stimulants, hallucinogens, inhalants, prescription drugs used without doctors' orders).	Ages 12–17 - FFY 2005 (Baseline)	6.70	
		Ages 18+ - FFY 2005 (Baseline)	3.80	

((s)) indicates that the respondents to the question may not constitute a representative sample. All NSDUH data are based on pooled 2004-2005 samples.

† NSDUH asks separate questions for each tobacco product. The number provided combines responses to all questions about tobacco products other than cigarettes.
‡ NSDUH asks separate questions for each illegal drug. The number provided combines responses to all questions about illegal drugs other than marijuana or hashish.

Form P2

NOMs Domain: Reduced Morbidity—Abstinence from Drug Use/Alcohol Use
Measure: Perception of Risk/Harm of Use

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
1. Perception of Risk From Alcohol	**Source Survey Item:** NSDUH Questionnaire: "How much do people risk harming themselves physically and in other ways when they have five or more drinks of an alcoholic beverage once or twice a week?" [Response options: No risk, slight risk, moderate risk, great risk] **Outcome Reported:** Percent reporting moderate or great risk.	Ages 12–17 - FFY 2005 (Baseline)	80.20	
		Ages 18+ - FFY 2005 (Baseline)	80.10	
2. Perception of Risk From Cigarettes	**Source Survey Item:** NSDUH Questionnaire: "How much do people risk harming themselves physically and in other ways when they smoke one or more packs of cigarettes per day?" [Response options: No risk, slight risk, moderate risk, great risk] **Outcome Reported:** Percent reporting moderate or great risk.	Ages 12–17 - FFY 2005 (Baseline)	91.50	
		Ages 18+ - FFY 2005 (Baseline)	93.90	
3. Perception of Risk From Marijuana	**Source Survey Item:** NSDUH Questionnaire: "How much do people risk harming themselves physically and in other ways when they smoke marijuana once or twice a week?" [Response options: No risk, slight risk, moderate risk, great risk] **Outcome Reported:** Percent reporting moderate or great risk.	Ages 12–17 - FFY 2005 (Baseline)	83.50	
		Ages 18+ - FFY 2005 (Baseline)	82.70	

((s)) indicates that the respondents to the question may not constitute a representative sample. All NSDUH data are based on pooled 2004-2005 samples.

Form P3

NOMs Domain: Reduced Morbidity—Abstinence from Drug Use/Alcohol Use
Measure: Age of First Use

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
1. Age at First Use of Alcohol	**Source Survey Item:** NSDUH Questionnaire: "Think about the first time you had a drink of an alcoholic beverage. How old were you the first time you had a drink of an alcoholic beverage? Please do not include any time when you only had a sip or two from a drink." [Response option: Write in age at first use.] **Outcome Reported:** Average age at first use of alcohol.	Ages 12–17 - FFY 2005 (Baseline)	12.80	
		Ages 18+ - FFY 2005 (Baseline)	17.80	
2. Age at First Use of Cigarettes	**Source Survey Item:** NSDUH Questionnaire: "How old were you the first time you smoked part or all of a cigarette?" [Response option: Write in age at first use.] **Outcome Reported:** Average age at first use of cigarettes.	Ages 12–17 - FFY 2005 (Baseline)	12.10	
		Ages 18+ - FFY 2005 (Baseline)	15.90	
3. Age at First Use of Tobacco Products Other Than Cigarettes	**Source Survey Item:** NSDUH Questionnaire: "How old were you the first time you used [any other tobacco product] † ?" [Response option: Write in age at first use.] **Outcome Reported:** Average age at first use of tobacco products other than cigarettes.	Ages 12–17 - FFY 2005 (Baseline)	12.50	
		Ages 18+ - FFY 2005 (Baseline)	18.80	
4. Age at First Use of Marijuana or Hashish	**Source Survey Item:** NSDUH Questionnaire: "How old were you the first time you used marijuana or hashish?" [Response option: Write in age at first use.] **Outcome Reported:** Average age at first use of marijuana or hashish.	Ages 12–17 - FFY 2005 (Baseline)	13.40	
		Ages 18+ - FFY 2005 (Baseline)	18.50	
5. Age at First Use of Illegal Drugs Other Than Marijuana or Hashish	**Source Survey Item:** NSDUH Questionnaire: "How old were you the first time you used [other illegal drugs] ‡ ?" [Response option: Write in age at first use.] **Outcome Reported:** Average age at first use of other illegal drugs.	Ages 12–17 - FFY 2005 (Baseline)	12.20	
		Ages 18+ - FFY 2005 (Baseline)	19.90	

((s)) indicates that the respondents to the question may not constitute a representative sample. All NSDUH data are based on pooled 2004-2005 samples.

† The question was asked about each tobacco product separately, and the youngest age at first use was taken as the measure.
‡ The question was asked about each drug in this category separately, and the youngest age at first use was taken as the measure.

Form P4

NOMs Domain: Reduced Morbidity—Abstinence from Drug Use/Alcohol Use
Measure: Perception of Disapproval/Attitudes

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
1. Disapproval of Cigarettes	**Source Survey Item:** NSDUH Questionnaire: "How do you feel about someone your age smoking one or more packs of cigarettes a day?" [Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove] **Outcome Reported:** Percent somewhat or strongly disapproving.	Ages 12–17 - FFY 2005 (Baseline)	87.20	
2. Perception of Disapproval of Cigarettes	**Source Survey Item:** NSDUH Questionnaire: "How do you think your close friends would feel about you smoking one or more packs of cigarettes a day?" [Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove] **Outcome Reported:** Percent reporting that their friends would somewhat or strongly disapprove.	Ages 12–17 - FFY 2005 (Baseline)	83.60	
3. Disapproval of Using Marijuana Experimentally	**Source Survey Item:** NSDUH Questionnaire: "How do you feel about someone your age trying marijuana or hashish once or twice?" [Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove] **Outcome Reported:** Percent somewhat or strongly disapproving.	Ages 12–17 - FFY 2005 (Baseline)	83	
4. Disapproval of Using Marijuana Regularly	**Source Survey Item:** NSDUH Questionnaire: "How do you feel about someone your age using marijuana once a month or more?" [Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove] **Outcome Reported:** Percent somewhat or strongly disapproving.	Ages 12–17 - FFY 2005 (Baseline)	83	
5. Disapproval of Alcohol	**Source Survey Item:** NSDUH Questionnaire: "How do you feel about someone your age having one or two drinks of an alcoholic beverage nearly every day?" [Response options: Neither approve nor disapprove, somewhat disapprove, strongly disapprove] **Outcome Reported:** Percent somewhat or strongly disapproving.	Ages 12–17 - FFY 2005 (Baseline)	83.50	

((s)) indicates that the respondents to the question may not constitute a representative sample. All NSDUH data are based on pooled 2004-2005 samples.

Form P5

NOMs Domain: Employment/Education
Measure: Perception of Workplace Policy

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
Perception of Workplace Policy	**Source Survey Item:** NSDUH Questionnaire: "Would you be more or less likely to want to work for an employer that tests its employees for drug or alcohol use on a random basis? Would you say more likely, less likely, or would it make no difference to you?" [Response options: More likely, less likely, would make no difference] **Outcome Reported:** Percent reporting that they would be more likely to work for an employer conducting random drug and alcohol tests.	Ages 15–17 - FFY 2005 (Baseline)	((s))	
		Ages 18+ - FFY 2005 (Baseline)	57.60	

((s)) indicates that the respondents to the question may not constitute a representative sample. All NSDUH data are based on pooled 2004-2005 samples.

Form P7

NOMs Domain: Employment/Education

Measure: Average Daily School Attendance Rate

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
Average Daily School Attendance Rate	**Source:**National Center for Education Statistics, Common Core of Data: The National Public Education Finance Survey available for download at http://nces.ed.gov/ccd/stfis.asp **Measure calculation:** Average daily attendance (NCES defined) divided by total enrollment and multiplied by 100.	FFY 2005 (Baseline)	96.60	

((s)) indicates that the respondents to the question may not constitute a representative sample. All NSDUH data are based on pooled 2004-2005 samples.

Form P8

NOMs Domain: Crime and Criminal Justice
Measure: Alcohol-Related Traffic Fatalities

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
Alcohol-Related Traffic Fatalities	**Source:** National Highway Traffic Safety Administration Fatality Analysis Reporting System **Measure calculation:** The number of alcohol-related traffic fatalities divided by the total number of traffic fatalities and multiplied by 100.	FFY 2005 (Baseline)	37	

((s)) indicates that the respondents to the question may not constitute a representative sample. All NSDUH data are based on pooled 2004-2005 samples.

Form P9

NOMs Domain: Crime and Criminal Justice
Measure: Alcohol- and Drug-Related Arrests

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
Alcohol- and Drug-Related Arrests	**Source:** Federal Bureau of Investigation Uniform Crime Reports **Measure calculation:** The number of alcohol- and drug-related arrests divided by the total number of arrests and multiplied by 100.	FFY 2005 (Baseline)	100	

((s)) indicates that the respondents to the question may not constitute a representative sample. All NSDUH data are based on pooled 2004-2005 samples.

Form P10

NOMs Domain: Social Connectedness

Measure: Family Communications Around Drug and Alcohol Use

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
1. Family Communications Around Drug and Alcohol Use (Parents of children aged 12–17)	**Source Survey Item:** NSDUH Questionnaire: "Now think about the past 12 months, that is, from **[DATEFILL]** through today. During the past 12 months, have you talked with at least one of your parents about the dangers of tobacco, alcohol, or drug use? By parents, we mean either your biological parents, adoptive parents, stepparents, or adult guardians, whether or not they live with you." [Response options: Yes, No] **Outcome Reported:** Percent reporting having talked with a parent.	Ages 12–17 - FFY 2005 (Baseline)	60.20	
2. Family Communications Around Drug and Alcohol Use (Parents of children aged 12–17)	**Source Survey Item:** NSDUH Questionnaire: "During the past 12 months, how many times have you talked with your child about the dangers or problems associated with the use of tobacco, alcohol, or other drugs?" † [Response options: 0 times, 1 to 2 times, a few times, many times] **Outcome Reported:** Percent of parents reporting that they have talked to their child.	Ages 18+ - FFY 2005 (Baseline)	94.20	

((s)) indicates that the respondents to the question may not constitute a representative sample. All NSDUH data are based on pooled 2004-2005 samples.

† NSDUH does not ask this question of all sampled parents. It is a validation question posed to parents of 12- to 17-year-old survey respondents. Therefore, the responses are not representative of the population of parents in a State. The sample sizes are often too small for valid reporting.

Form P11

NOMs Domain: Retention

Measure: Percentage of Youth Seeing, Reading, Watching, or Listening to a Prevention Message

A. Measure	B. Question/Response		C. Pre-Populated Data	D. Approved Substitute Data
Exposure to Prevention Messages	**Source Survey Item:** NSDUH Questionnaire: "During the past 12 months, do you recall [hearing, reading, or watching an advertisement about the prevention of substance use] † ?" **Outcome Reported:** Percent reporting having been exposed to prevention message.	Ages 12–17 - FFY 2005 (Baseline)	91.50	

((s)) indicates that the respondents to the question may not constitute a representative sample. All NSDUH data are based on pooled 2004-2005 samples.

† This is a summary of four separate NSDUH questions each asking about a specific type of prevention message delivered within a specific context.

Form P12A

Programs and Strategies—Number of Persons Served by Age, Gender, Race, and Ethnicity

Question 1: Describe the data collection system you used to collect the NOMs data (e.g., MDS, DbB, KIT Solutions, manual process).

The data was collected through a manual process, submitting paper forms that were then logged to a database.

Question 2: Describe how your State's data collection and reporting processes record a participant's race, specifically for participants who are more than one race. Indicate whether the State added those participants to the number for each applicable racial category or whether the State added all those participants to the More Than One Race subcategory.

Those participants who indicated more than one race were put in the "More than One Race" subcategory which has a total of 659 individuals.

Category	Description	Total Served
A. Age	1. 0-4	256
	2. 5-11	2654
	3. 12-14	7968
	4. 15-17	6506
	5. 18-20	1654
	6. 21-24	349
	7.25-44	458
	8. 45-64	293
	9. 65 And Over	0
	10. Age Not Known	450
B. Gender	Male	12437
	Female	8104
	Gender Unknown	47
	White	12376
	Black or African American	6543

C. Race		
	Native Hawaiian/Other Pacific Islander	12
	Asian	320
	American indian/Alaska Native	134
	Race Unknown or Other (not OMB required)	544
D. Ethnicity	Hispanic or Latino	3456
	Not Hispanic or Latino	17132

Form P12B

Population-Based Programs and Strategies—Number of Persons Served by Age, Gender, Race, and Ethnicity

Category	Description	Total Served
A. Age	1. 0-4	
	2. 5-11	
	3. 12-14	
	4. 15-17	
	5. 18-20	
	6. 21-24	
	7.25-44	
	8. 45-64	
	9. 65 And Over	
	10. Age Not Known	20000
B. Gender	Male	
	Female	
	Gender Unknown	20000
C. Race	White	
	Black or African American	
	Native Hawaiian/Other Pacific Islander	
	Asian	
	American indian/Alaska Native	
	Race Unknown or Other (not OMB required)	20000

D. Ethnicity	Hispanic or Latino	
	Not Hispanic or Latino	

Form P13

Number of Persons Served by Type of Intervention

Intervention Type	Number of Persons Served by Individual- or Population-Based Program or Strategy	
	A. Individual-Based Programs and Strategies	B. Population-Based Programs and Strategies
1. Universal Direct	17432	N/A
2. Universal Indirect	N/A	20000
3. Selective	2954	N/A
4. Indicated	202	N/A
5. Total	20588	20000

Form P14

Evidence-Based Programs and Strategies by Type of Intervention

NOMs Domain: Retention
NOMs Domain: Evidence-Based Programs and Strategies
Measure: Number of Evidence-Based Programs and Strategies

Definition of Evidence-Based Programs and Strategies: The guidance document for the Strategic Prevention Framework State Incentive Grant, Identifying and Selecting Evidence-based Interventions, provides the following definition for evidence-based programs:

- Inclusion in a Federal List or Registry of evidence-based interventions
- Being reported (with positive effects) in a peer-reviewed journal
- Documentation of effectiveness based on the following guidelines:
  - Guideline 1: The intervention is based on a solid theory or theoretical perspective that has validated research, and
  - Guideline 2: The intervention is supported by a documented body of knowledge—a converging of empirical evidence of effectiveness—generated from similar or related interventions that indicate effectiveness, and
  - Guideline 3: The intervention is judged by informed experts to be effective (i.e., reflects and documents consensus among informed experts based on their knowledge that combines theory, research, and practice experience). "Informed experts" may include key community prevention leaders, and elders or other respected leaders within indigenous cultures.

1. Describe the process the State will use to implement the guidelines included in the above definition.
We collect data on which programs are being used by each provider, then validate whether each program is or is not evidence-based using the criteria above.

2. Describe how the State collected data on the number of programs and strategies. What is the source of the data?
Data on the strategies is collected on an ongoing basis as part of the same collection from that gives us information or participants.

Number of Evidence-Based Programs and Strategies by Type of Intervention

	A. Universal Direct	B. Universal Indirect	C. Universal Total	D. Selected	E. Indicated	F. Total
1. Number of Evidence-Based Programs and Strategies Funded	22	1	23	3	1	27
2. Total number of Programs and Strategies Funded	27	3	30	4	2	36
3. Percent of Evidence-Based Programs and Strategies	81.48%	33.33%	76.67%	75.00%	50.00%	75.00%

Form P15

Services Provided Within Cost Bands

Type of Intervention	A. Number of Programs and Strategies	B. Number of Programs and Strategies Falling Within Cost Bands	C. Percent of Programs and Strategies Falling Within Cost Bands
1. Universal Direct Programs and Strategies	27	15	56 %
2. Universal Indirect Programs and Strategies	3	3	100 %
3. Subtotal Universal Programs	30	18	60.00%
4. Selective Programs and Strategies	4	4	100 %
5. Indicated Programs and Strategies	2	2	100 %
6. Total All Programs	36	24	66.67%

Alabama

Prevention Corrective Action Plan (submit upon request)

1. Describe the corrective action plan, including critical steps and actions the State and its providers will employ to collect and report the National Outcome Measures data.

2. Discuss the timeframes for the State's corrective action plan detailing the planned milestones and other measures of progress the State has incorporated into its corrective action plan.

3. Describe the State's corrective action plan implementation monitoring activities including interventions or adjustments the State will employ when timeframes or milestones are not achieved.

Approved Substitute Data Submission Form

Substitute data has not been submitted for prevention forms.

Prevention Attachment D:
2005 Block Grant Subrecipient Cost Band Worksheet

Subrecipient Name:_____

Date Form Completed:_____

Name of Contact Person:_____

Phone:_____ **E-mail Address:**_____

Table 1: Progam Detail

1	2	3	4	5	6
Program Name	**Number of Participants**	**Number of Program Hours Received**	**Total Cost of the Program**	**Average Cost Per Participant (Col 4/Col 2)**	**Average Cost Per Participant Falls Within 2005 Cost Bands (Yes=1 No=0)**
Universal Direct Programs					**Universal Direct: $58.01–$693.98**
1.					
2.					
3.					
4.					
Universal Indirect Programs					**Universal Indirect $1.05–$82.26**
1.					
2.					
3.					
4.					
Selective Programs					**Selective $151.88–$6,409.29**
1.					
2.					
3.					
4.					
Indicated Programs					**Indicated $510.47–$4,888.44**
1.					
2.					
3.					
4.					

Table 2: Subrecipient Cost Band Summary

	1	2
Program Type	**Number of Programs**	**Number of Programs Falling Within Cost Bands**
Universal Direct		
Universal Indirect		
Selective		
Indicated		
Total		

Instructions for Completing the 2005 Block Grant Subrecipient Cost Band Worksheet

The 2005 Block Grant Subrecipient Cost Band Worksheet is an optional tool that States may use for their providers to record the number of program participants, the number of hours received, the cost of each program, the average cost per program participant, and the number of programs whose average participant costs fall within the 2005 cost bands. Data should be based on total cost of program not only the funding from CSAP. States may use an alternative approach to obtain data used to report the aggregate cost band data in Form P15 of the SAPT Block Grant Application. These worksheets are not required as part of that submission.

1. Subrecipient Information

Grant Information. At the top of the page, enter the name of the subrecipient, the contact information for the person completing this form, and the date on which the form was completed.

2. Table 1: Program Detail

Column 1: Program Name. In column 1, list the names of all programs that were funded in whole or in part with Block Grant funds during Federal fiscal year (FY) 2005. Add additional rows if necessary.

A program is defined as an activity, a strategy, or an approach intended to prevent an outcome or to alter the course of an existing condition. In substance abuse prevention, interventions may be used to prevent or lower the rate of substance use or substance abuse-related risk factors.

Separate table sections are provided for programs that are defined as Universal Direct, Universal Indirect, Selective, and indicated. Universal indirect services are defined as services that support prevention activities, such as population-based activities, and the provision of information and technical assistance. Universal direct, selective, and indicated services are defined as prevention program interventions that directly serve participants.

- ***Universal.*** Activities targeted to the general public or a whole population group that has not been identified on the basis of individual risk.
    - ***Universal Direct.*** Interventions directly serve an identifiable group of participants but who have not been identified on the basis of individual risk (e.g., school curriculum, afterschool program, parenting class). This also could include interventions involving interpersonal and ongoing/repeated contact (e.g., coalitions).
    - ***Universal Indirect***. Interventions support population-based programs and environmental strategies (e.g., establishing ATOD policies, modifying ATOD advertising practices). This also could include interventions involving programs and policies implemented by coalitions.
- ***Selective.*** Activities targeted to individuals or a subgroup of the population whose risk of developing a disorder is significantly higher than average.
- ***Indicated.*** Activities targeted to individuals identified as having minimal but detectable signs or symptoms foreshadowing disorder or having biological markers indicating predisposition for disorder but not yet meeting diagnostic levels.

Column 2: Number of Participants. In this column, specify the number of participants who took part in the preventive program during FY 2005. If this intervention was delivered to multiple groups, combine all groups and report the total. If it is an indirect program, use the estimated number of people reached during the reporting year.

Column 3: Number of Program Hours Received. In this column, report the number of hours that program participants received over the course of the program.

Column 4: Total Cost of This Program. In this column, report the total of all costs expended on the program during the reporting year. This should include all costs associated with the program, such as staff training, staff time, and materials, during the year.

Column 5: Average Cost Per Participant. Report the average cost per participant. Calculate the average cost by dividing the Block Grant dollars expended on each program (column 4) by the number of participant s served (column 2).

Column 6: Average Cost Per Participant Falls Within Cost Bands. Compare the average cost per participant (column 5) with the 2005 cost bands for each program type. If the average cost per participant falls within the specified interval, record a "1" in column 5. If the average cost is either higher or lower than the cost band interval, enter a zero in column 5.

3. Table 2: Subrecipient Cost Band Summary

Table 2 summarizes information recorded in Table 1.

Column 1: Number of Programs. In column 1, enter the total number of programs on which you reported in Table 1, by program types (Universal Direct, Universal Indirect, Selective, and Indicated). Total the number of programs in the last row.

Column 2: Number of Programs Falling Within Cost Bands. For each program type, enter the total number of programs that fell within the cost bands for that program type (i.e., programs that were coded "1" in Table 1, column 5).

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Appendix A - Additional Supporting Documents (Optional)

Appendix A - Additional Supporting Documents (Optional)
No additional documentation is required to complete your application, besides those referenced in other sections. This area is strictly optional. However, if you wish to add extra documents to support your application, please attach it (them) here. If you have multiple documents, please 'zip' them together and attach here.